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Ontario

ROYAL COMMISSION OF INQUIRY INTO CERTAIN  
DEATHS AT THE HOSPITAL FOR SICK CHILDREN AND  
RELATED MATTERS.

Hearing held  
21st floor  
180 Dundas Street West  
Toronto, Ontario

The Honourable Mr. Justice S.G.M. Grange

Commissioner

P.S.A. Lamok, Q.C.

Counsel

E.A. Cronk

Associate Counsel

Thomas Millar

Administrator

Transcript of evidence  
for

4 June, 1984

VOLUME 148

OFFICIAL COURT REPORTERS

Angus, Stonehouse & Co. Ltd.,  
14 Carlton Street, 7th Floor,  
Toronto, Ontario M5B 1J2

595-1065







ROYAL COMMISSION OF INQUIRY INTO CERTAIN  
DEATHS AT THE HOSPITAL FOR SICK CHILDREN  
AND RELATED MATTERS.

Hearing held on the 21st Floor,  
180 Dundas Street West, Toronto,  
Ontario, on Monday, the 4th day  
of June, 1984.

- - - -

THE HONOURABLE MR. JUSTICE S.G.M. GRANGE - Commissioner  
THOMAS MILLAR - Administrator  
MURRAY R. ELLIOT - Registrar

APPEARANCES:

P.S.A. LAMEK, Q.C.	)	Commission Counsel
E. CRONK	)	
D. HUNT	)	Counsel for the Attorney
L. CECCHETTO	)	General and Solicitor
		General of Ontario (Crown
		Attorneys and Coroner's
		Office)
B. PERCIVAL, Q.C.	)	Counsel for The Metropolitan
D. YOUNG	)	Toronto Police
W.N. ORTVED	)	Counsel for numerous
K. CHOWN	)	Doctors at The Hospital
	)	for Sick Children
F. KITELY	)	Counsel for the Registered
		Nurses Association of
		Ontario and 35 Registered
		Nurses at The Hospital for
		Sick Children
D. BROWN	)	Counsel for Susan Nelles -
		Nurse

(Cont'd)....



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APPEARANCES: (Cont'd)

G.R. STRATHY	)	Counsel for Phyllis Trayner - Nurse
J. OLAH	)	Counsel for Janet Brownless - Nurse
S. LABOW	)	Counsel for Mr. & Mrs. Gosselin, Mr. & Mrs. Gionas, Mr. & Mrs. Inwood, Mr. & Mrs. Turner, Mr. & Mrs. Lutes, and Mr. & Mrs. Murphy (Parents of deceased children)
F.J. SHANAHAN		Counsel for Mr. & Mrs. Dominic Lombardo (parents of deceased child Stephanie Lombardo); and Heather Dawson (mother of deceased child Amber Dawson)
W.W. TOBIAS		Counsel for Mr. & Mrs. Hines (parents of deceased child Jordan Hines)
J. SHINEHOFT		Counsel for Lorie Pacsai and Kevin Garnet (parents of deceased child Kevin Pacsai)

VOLUME 148





E R R A T A

VOLUME 145

- Page 3358, line 22: reads "receive" should read  
"leave"
- Page 3389, line 17: reads "tach" should read "tet"
- Page 3432, line 9: reads "start digoxin" should read  
"stop digoxin"
- Page 3492, line 21: reads "he" should read "you"

VOLUME 146

- Page 3530, line 20: reads "associated" should read  
"associate"
- Page 3537, line 15: reads " own their sauces"  
should read "and their sauces"
- Page 3539, line 18: reads "position order" should  
read "physician order"
- Page 3551, line 8: reads "can't perform to X"  
should read "can perform to X"
- Page 3627, line 3: reads "required to stat" should  
"required stat"







I N D E X

ARGUMENT BY MR. LAMEK 125

I N D E X O F E X H I B I T S

<u>NO.</u>	<u>Description</u>	<u>PAGE NO.</u>
420	Amending Order-in-Council	2
421	Letter from Dr. DeSa	123
422	Coroner's investigation statements	124







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---On commencing at 10:00 a.m.

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THE COMMISSIONER: Yes, Mr. Lamek?

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MR. LAMEK: I thought, Mr. Commissioner,  
you were first going to read the decision on the  
argument?

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THE COMMISSIONER: Yes. I am  
certainly going to do that. I thought the first thing,  
though, was to handle the Phase II problem, was it  
not?

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MR. LAMEK: Whatever you say, sir.

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THE COMMISSIONER: I think what I  
would like to do first is to get Phase II out of  
the way for the time being, and I think we should  
have - you haven't the formal Order-in-Council?

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MR. LAMEK: No.

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THE COMMISSIONER: We should have a  
copy and then we can deal with standing.

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MR. LAMEK: You are absolutely right,  
Mr. Commissioner. I do not yet have a signed copy  
of the amending Order-in-Council, but I sent to all  
Counsel a copy of the unsigned version. And perhaps  
for the time being in order that argument as to stand-  
ing may have some standing, I could file the unsigned  
copy as the next exhibit, please.

23

24

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THE COMMISSIONER: All right. The





1  
2 amendment, and we will substitute the signed one when  
3 we get it, the amendment to the Order-in-Council.

4 MR. PERCIVAL: What is the number,  
5 Mr. Commissioner?

6 THE COMMISSIONER: 420.

7 MR. PERCIVAL: Thank you.

8 ---EXHIBIT NO. 420: Amending Order-in-Council  
9

10 THE COMMISSIONER: We have not had  
11 any chance to discuss that I read in the papers that  
12 I said we were going on and I read in the papers  
13 that Mr. Percival said that's all right by him. Do  
14 I have that correctly?

15 MR. PERCIVAL: Yes.

16 THE COMMISSIONER: All right.

17 MR. PERCIVAL: A very excellent  
18 paraphrase.

19 THE COMMISSIONER: That being the case  
20 I would like to dispose of the standing problem in  
21 Phase II, not necessarily today, but I would like to  
22 know precisely... Now I don't think there is any  
23 question about Susan Nelles, the Attorney General,  
24 Metropolitan Police and I really don't think there  
25 is much question about the Hospital either, but first  
of all, are all of those four seeking standing?







1  
2 MR. BROWN: Yes, we are seeking  
3 standing on behalf of Miss Nelles.

4 THE COMMISSIONER: And are you seeking  
5 standing, Mr. Hunt?

6 MR. HUNT: Oh, yes.

7 THE COMMISSIONER: Yes, Mr. Percival.

8 MS. THOMSON: Yes, we are.

9 THE COMMISSIONER: And Miss Thomson.

10 I guess Mr. Lamek has standing too.  
11 Now who else would like standing?

12 MR. ORTVED: I can tell you, Mr.  
13 Commissioner, on behalf of the 40 odd doctors whom  
14 I am retained to represent that I will be making an  
15 application for standing in their behalf.

16 THE COMMISSIONER: Yes. All right.  
17 Miss Kitley?

18 MISS KITELY: Mr. Commissioner, on  
19 behalf of the 39 individuals we represent and the  
20 Registered Nurses Association, I wish to make sub-  
21 missions.

22 THE COMMISSIONER: The doctors and  
23 nurses are in a different category, but the Registered  
24 Nurses Association, I think in light of what -  
25 certainly in light of what Mr. Hunt and Mr. Young  
have said in camera the other day would not have







1  
2 any position at all. Now they may, of course, support  
3 the individual nurses, but why would they have any right  
4 to standing?

5 MISS KITELY: Well, I am prepared to  
6 make submissions on both, sir. Do you wish to hear  
7 from me now or are you polling --

8 THE COMMISSIONER: I guess you are  
9 right. 39 and the Registered Nurses Association.  
10 All right. That is probably sensible to just  
11 know who it is. Now, Mr. Labow?

12 MR. LABOW: Mr. Commissioner, on behalf  
13 of the six families we represent as well as the  
14 family of Justin Cook we will be seeking standing  
15 in the second phase, and at this point I would also  
16 like to ask that we be given standing at this point  
17 in Phase I for the family of Justin Cook.

18 We were only contacted last week to  
19 ask for standing in this matter.

20 I feel that Commission Counsel has done  
21 an exceptional job in going through the evidence  
22 regarding the Cook child, but I would like standing  
23 and the opportunity to make submissions about that  
24 child when we turn to submissions in Phase I.

25 THE COMMISSIONER: There is no extra  
evidence I take it?





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MR. LABOW: None that I know of.

THE COMMISSIONER: You had better know pretty fast.

MR. LABOW: We were only retained this morning. I spoke to them late last week.

THE COMMISSIONER: Yes. All right. If there is any one, any opposition provided no evidence is called to Mr. Labow acting for the family of Justin Cook? Well, that certainly - yes, Mr. Shinehoft?

MR. SHINEHOFT: No, I have no --

THE COMMISSIONER: Well, I will just deal with that, and certainly as far as I am concerned I am happy to have Justin Cook's parents represented by you.

I take it that that will mean that you will submit an argument on behalf of him as well as on behalf of your other clients?

MR. LABOW: Yes.

THE COMMISSIONER: You are able to do that without causing us any delay?

MR. LABOW: I hope that is the case. I think I can do that without causing any delay.

THE COMMISSIONER: All right. Thank you.

Mr. Shinehoft?







1  
2 MR. SHINEHOFT: Yes. I am making a  
3 formal application, Mr. Commissioner, to have standing  
4 in Phase II on behalf of my clients.

5 THE COMMISSIONER: Yes. All right.  
6 I would have said some things to you, but I will wait  
7 and we will take them in order as we go along.

8 Anyone else seeking standing?

9 MR. STRATHY: Yes, Mr. Commissioner.  
10 For reasons which I would like to have an opportunity  
11 to elaborate at some stage, I will be requesting  
12 standing on behalf of my client, Mrs. Trayner, during  
13 Phase II.

14 THE COMMISSIONER: Yes. All right.

15 Anyone else?

16 I think you have an indication, have  
17 you not, Mr. Lamek, that certain counsel are not  
18 participating further?

19 MR. LAMEK: Yes, I do, sir. I've heard  
20 from counsel for Nurse Scott who say they will not  
21 be seeking standing, and Mr. Olah has said the same  
22 thing for Miss Brownless as has Mr. Knazan and Miss  
23 Solomon on behalf of their client, Mrs. Christie.

24 THE COMMISSIONER: Then there is Mr.  
25 Rosenberg and Mr. Knazan and Miss Solomon. Anyone  
else?





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MR. LAMEK: For Mrs. Christie and  
therefore the RNAA.

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THE COMMISSIONER: Yes. All right.  
Thank you.

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MR. LABOW: Because Mr. Tobias and  
Mr. Shanahan aren't here, I can indicate to you in  
our last discussion Mr. Tobias was going to seek  
standing for the Hines family and at my last indication  
Mr. Shanahan was also going to seek standing in  
Phase II for the Dawson and the Lombardo families.

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THE COMMISSIONER: I don't imagine  
the argument is much different between them and you,  
but the problem is --

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MR. LABOW: I don't imagine.

THE COMMISSIONER: - I want to proceed  
with the argument right now and get it out of the  
way.

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MR. LABOW: I expected both of them  
to be here.

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THE COMMISSIONER: Yes. All right.  
Then can I hear if anyone has any  
objection to the standing of Susan Nelles, the  
Attorney General, the Police and the Hospital? Is  
anyone opposed to their having standing? And before  
I forget is there anyone else seeking standing who was







1  
2 not represented in Phase I?

3 All right. In that event we will give  
4 standing to Susan Nelles, the Attorney General, the  
5 Police and the Hospital, and we won't have to hear  
6 from them on that subject.

7 I would like to hear from you, Mr.  
8 Ortved, as to why the doctors should have standing.

9 MR. ORTVED: Thank you, Mr. Commissioner.

10 The context in which I put my submissions  
11 to you is that delineated by the Public Inquiries Act,  
12 and particularly that section permitting that you may  
13 allow standing to a party with a direct and substantial  
14 interest. It is my submission to you that the doctors  
15 whom I represent have that direct and substantial  
16 interest.

17 I have provided on a prior occasion a  
18 list of the doctors for whom I am retained to act to  
19 Commission Counsel, but for the purposes of your  
20 understanding my submissions to you today I can tell  
21 you that they include, for example, the cardiologists,  
22 comprising the Division of Cardiology in the Hospital  
23 for Sick Children, a number of pathologists including  
24 Dr. Phillips, the head of Pathology, Hospital for  
25 Sick Children, as well as Dr. Hill, for instance, the  
head of the Division of Biochemistry, and other doctors





1  
2 spread throughout the Hospital, comprising doctors in  
3 charge of clinical care, the surgeons who performed  
4 the surgical procedures on those involved and other  
5 doctors otherwise indicated.

6 I suppose one hurdle I have to over-  
7 come is a possible perception on your part that the  
8 position of the doctors is in no way different from that  
9 of the Hospital, and really why is the direct and substantial  
10 interest of the doctors not adequately covered by  
11 counsel here on behalf of the Hospital. Simply  
12 stated --

13 THE COMMISSIONER: There is another  
14 problem. As I see it the only problem that the doctors  
15 face, and the same thing applies to the nurses, is that  
16 it may be alleged that some of them, some of them  
17 individually, were not as co-operative as they might  
18 have been in the Police investigation.

19 Is there any other conceivable interest  
20 that the doctors could have?

21 MR. ORTVED: Well --

22 THE COMMISSIONER: Other than that of  
23 the curious interest which is not an interest in law.

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MR. ORTVED: I don't think the doctor's interest in Phase II is so very different from that in Phase I. Our submission to you will be that the doctor's response in the circumstances is adequate and understandable. I think in Phase II it is very conceivable that part of the case on the part of the police that that was not the case.

THE COMMISSIONER: What was not the case?

MR. ORTVED: That their response was both inadequate and not capable of comprehension. In that very context I need refer you , Mr. Commissioner, no further than the meeting that took place at the coroner's office on March the 21st, I believe it was -- March 20th, and the suggestions raised at that time that certain actions were not taken that may be should have been taken.

There is a suggestion that how is it conceivable at this stage that the circumstances concerning the Allana Miller child were not raised for the officials at that meeting and the doctors had given you their clear evidence as to why that was the case and then that had been met.

THE COMMISSIONER: That would apply only, of course, to the doctors who were there, the





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doctors who were at the meeting. It wouldn't apply to doctors, generally.

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MR. ORTVED: Well, I think to the extent that other doctors were interviewed and that those interviews surfaced in the course of this ensuing inquiry, you may find precisely the same questions were put, so I don't think it can be necessarily limited to just Dr. Rowe and Dr. Fowler, who were present at that meeting.

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This is the flavour, in my submission to you, that underlies the whole of Phase I and the whole of Phase II.

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THE COMMISSIONER: What would you want to do with respect to that meeting except to perhaps to protect the reputation of Dr. Rowe and Dr. Fowler? Is there anything else?

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MR. ORTVED: That is the crux, that is the second aspect of my application to you for standing, because we are dealing, firstly, with the position in the laws of these doctors, in the course of events leading up to March 20th or 21st, and the extent to which that is reflected in the evidence, up to that point in time, as well as after, and then, in particular, afterwards we are dealing with the reputations of these doctors and that is a







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very direct and substantial interest. That is what can become an issue in these proceedings as we all now know.

THE COMMISSIONER: If you are granted standing what would you suggest your participation should be in Phase II?

MR. ORTVED: Well, my participation in Phase II, I am prepared to concede at this point, is probably restricted to questions concerning the clients for whom I act and with the greatest of respect, Mr. Commissioner, that is I think I can say with some force, the attitude I adopted --

THE COMMISSIONER: Yes.

MR. ORTVED: -- during the course of Phase I.

THE COMMISSIONER: Well, if you take that position it may or may not be so difficult. If you take the position that you are concerned in the fight between Susan Nelles and the police then it would be very difficult; that is all.

MR. ORTVED: Absolutely not. I suppose I would be happiest, just slightly happier than you, if I could go through the whole of Phase II without saying a word, but I am applying for standing because I am concerned that that might not





B-4

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be the case.

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THE COMMISSIONER: Yes.

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MR. ORTVED: That is the concern

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of my clients.

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THE COMMISSIONER: Yes. All right,

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thank you.

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MR. ORTVED: I can continue.

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THE COMMISSIONER: Oh, all right,

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I am sorry.

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MR. ORTVED: But if you are telling me

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now that you are content to allow me standing then

I am not going to bore you.

13

THE COMMISSIONER: I am sorry, you

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have to continue. I am not saying that you aren't

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going to get standing either.

16

MR. ORTVED: Insofar as the difference

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between the Hospital and the doctors is concerned,

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simply stated, the Hospital is here on behalf of a

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number of individuals, as well as the institution.

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They represent nurses -- Mr. Scott represents nurses.

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He represents staff not concerned with the clinical  
care of the children. He represents the administration  
and he represents the Board of Trustees.

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The clients by whom I am obtained

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take the position that there is not an identity of

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interest or there are situations that can arise where there is not an identity of interest between those parties and their interests, therefore, they are asking that I make this application for standing on their individual behalf.

The only other matter which I draw to your attention is that I think that alone, of all the parties here, I can take the position for you to grant the standing is that it is no drain on the public purse to do so.

THE COMMISSIONER: Yes. All right, thank you.

Miss Kately, now I want to raise this question, first of all, the R.N.A.O., I want you to deal with them separately from the individual nurses.

MS. KATELY: I intend to do so, sir.

THE COMMISSIONER: Thank you.

If I could just eliminate standing for a lot of people there would be lots of room.

MS. KATELY: Mr. Commissioner, I intended to make remarks, both about the individuals and the Association, and I intended to do the Association last. It would follow logically if I did.

THE COMMISSIONER: All right.







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MS. KITELY: What I planned to do, sir, is do something that we have not had for some time and that is to refer to some law. If you will forgive me for a few moments I wish to refer you to the case of the Royal Commission on Conduct of Waste Management at the decision reported at 17 O.R. second at 207.

If I could pass a copy to my friend, Ms. Cronk, perhaps she could pass it forward to you. I don't have enough copies for all of the participants today, sir. I assume that not all would have as much of an interest in it as would you.

The section about which we are dealing, sir, is, of course, Section 5(1)(2) of the Act and that is set out on page 208 of the decision of the Waste Management case, on the bottom of the left hand side. In this particular case there had been a hearing before the Environmental Hearing Board and following that the Royal Commission was directed and the issue came on as to who had the status before the Royal Commission. As the case points out, on the top of page 208, on the left hand side, at the bottom of the first paragraph, "the subject matter of the inquiry concerns allegations of corruption and not pollution." People who were interested in obtaining





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standing were several individuals, a Mr. Hutchinson, for one, who was an adjacent land owner, an organization, and this is on page 211, sir, the top right hand side:

"POWR, an unincorporated association of concerned citizen known as, 'Protect Our Water Resources...'"

And, thirdly, Messrs. Sanders and Baker, who were officials of that unincorporated association.

The Court ultimately found that the adjacent land owner and the association ought to have standing, but that Messrs. Sanders and Baker, the officials of the unincorporated association, ought not to. In coming to that conclusion the Court had to deal with the relationship between 5(1) and 5(2) and concluded, if I can summarize, that you needn't be in a position of finding or making a finding of misconduct under Section 5(2), in order to conclude standing under Section 5(1).

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C-1

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2 In other words 5-1 is broader than  
3 5-2. The question stated by the Commissioner is  
4 of interest, and a way of pointing out to you,  
5 sir, at page 208 on the left hand side and I  
6 won't read it, but there the Commissioner has  
7 summarized the people that he was considering  
8 and those are the ones that I have just indicated  
9 to you.

10 Now Mr. Scott who was then  
11 acting on behalf of the Applicant made submissions  
12 which are summarized on page 210, on the left  
13 hand side, and the reasons on which his client  
14 the Applicant ought to be granted standing.  
15 There are paragraphs numbered 1, 2 and 3.

16 First of all, that the Applicants  
17 had participated in the process under review;  
18 and the process, sir, was the Environmental  
19 Hearing Board and therefore would have information  
20 to offer.

21 Secondly, that the Applicants  
22 would be affected, or have been affected by  
23 the results of the process and therefore have  
24 a substantial and direct interest.

25 And thirdly, the Applicants  
have made allegations of impropriety.





C-2

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2 The Court concluded, and this  
3 is at the bottom of page 210, sir, in granting  
4 standing to Mr. Hutchinson , they point out in  
5 the last full paragraph there:

6 " ...that he owned land  
7 adjacent to the landfill site.  
8 In our opinion on a proper  
9 interpretation of section 5-1  
10 the Commissioner ought to have  
11 been satisfied that Mr. Hutchinson  
12 has a substantial and direct  
13 interest in allegations of  
14 corruption which, if proven,  
15 may have affected the granting  
16 of a permit allowing the  
17 enlargement of the adjacent  
18 landfill site. "

19 Moving to the next paragraph, sir,  
20 the second point is with respect to POWR:

21 " All the individual Applicants  
22 are principal officers of  
23 that organization. POWR  
24 collectively and the individual  
25 Applicants, were all accorded  
standing before the Environmental





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Hearing Board, and made  
submissions.

They allege they are dissatisfied  
with the fairness of the hearing  
by the Board, and have called  
the integrity of that hearing  
into question. It is our  
opinion that, if the allegation  
of corruption which is the  
subject matter of the commission's  
enquiry could have had an  
influence on the conduct of  
the hearing and the decision of  
the Board in framing its  
recommendations to the Minister,  
they have a direct and substantial  
interest in the subject matter  
of the enquiry their interest  
lies in the integrity of the  
enquiry. They therefore agree  
with Mr. Scott that Mr. Hutchison  
POWR ought to be granted standing. "

But in the next paragraph, the second next  
paragraph, they reject Messrs. Sanders and Baker by  
reason of the fact that they are members of the







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unincorporated association which had already  
been, in their view, granted standing.

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In our submission, sir, applying  
the kinds of reasoning which the Court did in  
the Waste Management case, there are two particular  
reasons why the individual nurses ought to  
be granted standing. First of all, to use the  
words in the Waste Management case they participated  
in the process under review.

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THE COMMISSIONER: I'm sorry,  
no, they didn't, I am sorry nothing has been  
under review in Phase II yet. We are talking  
about Phase II?

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MS. KITELY: Yes, Phase II being  
the police investigation.

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THE COMMISSIONER: They participated  
in it?

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MS. KITELY: They participated  
in it.

THE COMMISSIONER: Yes, but  
be careful now, because that would mean everybody  
who was ever interviewed by the police would  
have a right to standing here.

MS. KITELY: I am sure you can figure a  
way around that, sir. In my submission, the nurses are





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on one side of the line by reason of their,  
particularly the ones who have already been  
called as witnesses, and the one at least who  
will be called as a witness, were very heavily  
involved in this investigation.

THE COMMISSIONER: I thought  
the matter under review by the Environmental  
Hearing Board was traditionally reviewed by the  
Divisional Court, isn't that so, was the matter  
under review there.

MS. KITELY: A public enquiry  
was started to review the Environmental Hearing  
Board.

THE COMMISSIONER: Yes, that's  
right.

MS. KITELY: By analogy, sir,  
there was a police investigation. There is  
a public enquiry to review the process of the  
police investigation and in my submission it  
is directly analogous.

THE COMMISSIONER: Well you have  
got to help me somehow, because obviously we  
cannot have everybody that was ever interviewed  
by the police or everybody who participated and  
who wrote a letter to the police suggesting somehow







C-6

1  
2 some solution, all of those people would be  
3 entitled too.

4 Surely the words of the  
5 Statute are important. Are you satisfied there  
6 is a substantial and direct interest in the  
7 subject matter of this enquiry. What is the  
8 substantial and direct interest of the nurses?

9 MS. KITELY: If I may continue,  
10 sir, the second point I will be dealing with  
11 your query, sir.

12 THE COMMISSIONER: Yes.

13 MS. KITELY: The second is, if  
14 you will assume with me for the moment that  
15 they did participate in the process under review,  
16 the nature of their participation has been  
17 very seriously called into question by my  
18 friends Mr. Hunt and Mr. Percival on behalf  
19 of the Attorney General and the Police. Some  
20 have been accused of being uncooperative, or  
21 of impeding or misleading the police in the  
22 investigation, and in the prosecution of the  
23 case against Susan Nelles.

24 If I can ask you to refer to  
25 certain portions of the evidence, sir, in this  
connection and what I have is a list of various





C-7

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2 excerpts from volume 96, 100, 101, 103, 104, 107  
3 and 128, and I have organized them in such  
4 a way that I can refer to them relatively  
5 quickly, sir. The objective of referring  
6 to these specific pieces of evidence is to show  
7 the extent to which the nurses in their  
8 participation in the enquiry was called into  
9 question. If I can deal, sir, with, and I  
10 have not made copies of all of them because  
11 my friends and I assume you also the Commissioner  
12 also has access to the transcripts. I have  
13 volume numbered the person who was examining  
14 and the page number and I will in each case  
15 provide those to you. In examination of nurse  
16 Costello in volume 96, by Mr. Hunt, at page 1615,  
17 Mr. Hunt suggested as follows:

18 " Q. Are you aware that the  
19 police value the opinions of  
20 people that they interview in  
21 connection with serious matters  
22 like this who are connected or  
23 associated in some way with  
24 the incident that they are  
25 investigating?

A. I assume so. "





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2 For the balance of the page, sir,  
3 and I am trying to be very collective about  
4 the portions that I read, Mr. Hunt was suggesting  
5 that the police treat these opinions and  
6 conjectures very seriously, and when Nurse  
7 Costello referred to the fact that with her silly  
8 thinking and conjecturing that was something  
9 of a criticism for her not offering on an  
10 unsolicited basis, certain opinions to the  
11 police.

11 THE COMMISSIONER: I am  
12 temporarily with you as I obviously was  
13 temporarily with Mr. Ortved too. When one of  
14 your clients is alleged not to have cooperated  
15 with the police I certainly think it would  
16 seem reasonable to have the right to assist  
17 the client, that is by either examination,  
18 cross-examination or something of that nature  
19 on the subject.

19 MS. KITELY: In Phase II, sir?

20 THE COMMISSIONER: I am talking  
21 about Phase II. I put the same question to  
22 you as I put to Mr. Ortved, are you concerned  
23 in the fight between Susan Nelles and the  
24 police?  
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MS. KITELY: Until we hear what happens in Phase II, I would have to say at this point, no.

THE COMMISSIONER: In other words, all you want to do in this matter is, where any of your clients are maligned you want to defend them, is that it?

MS. KITELY: No sir.

THE COMMISSIONER: What else do you want to do?

MS. KITELY: If I might ...

THE COMMISSIONER: Do you want to establish that the police did or did not do a good job?

MS. KITELY: On the point of Susan Nelles if I might finish with that, sir.

THE COMMISSIONER: Yes.

MS. KITELY: None of my clients at this point in time are defendants in that lawsuit and it is for that reason that I am saying it is not our position that we are involved in that fight.

THE COMMISSIONER: I am talking about the fight here, I am talking about our fight not that lawsuit, the fight that is





1  
2 existing here, the investigation and the  
3 prosecution of Susan Nelles. Are you --

4 MS. KITELY: To the extent in  
5 that respect that our clients get thrown into  
6 the fray; by way of suggestion there is  
7 the Bell evidence, and for example if that  
8 becomes an issue that that particular evidence  
9 somehow affected the resolution of issues  
10 between Nelles and the police then, yes, we  
11 could well be interested in that.

12 THE COMMISSIONER: I'm sorry,  
13 I don't understand that answer. I just really  
14 wanted to know whether you are concerned in  
15 that struggle.

16 MS. KITELY: All I can say,  
17 sir, is we don't know what Phase II is going  
18 to be.

19 THE COMMISSIONER: I don't  
20 either, but I do know what it is supposed  
21 to be, I have read the Order in Counsel and  
22 the Amendment and it is to investigate the  
23 circumstances of the investigation and the  
24 prosecution of Susan Nelles in the four infant  
25 deaths.

MS. KITELY: At this point in





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2 time all I can say, sir, is that on the face  
3 of it it appears we are not involved in the  
4 fight, to use your words, it is between  
5 Susan Nelles and the police, but it could  
6 happen during the course of the second Phase  
7 we may become --

8 THE COMMISSIONER: Ms. Kitley  
9 one of the things that I am concerned about,  
10 we have taken a year with Phase I and I don't  
11 want to take a year with Phase II. I now know,  
12 believe it or not, what this enquiry is all  
13 about.

14 MS. KITLEY: Can you tell the  
15 rest of us, sir?

16 THE COMMISSIONER: I may  
17 not know what I can put in the report, but  
18 I certainly know what it is all about. I don't  
19 want to waste a lot of time with cross-examination  
20 on subject matters that certain people are  
21 not interested in, they have no direct or  
22 substantial interest in. You certainly have  
23 an interest in your client's individual  
24 reputation. If it is alleged - for a while  
25 I was going to say to you, I really don't think  
there is - there may be a duty upon a citizen







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to cooperate with the police, there is certainly  
not a legal obligation that I know of upon  
a citizen to cooperate with the police.

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Therefore I would not have thought it was  
misconduct within the meaning of section 5 of  
the Public Enquiries Act, if they didn't.

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2 But I now have reached the conclusion that if somebody  
3 alleges that one of your clients, take for example,  
4 that Bertha Bell was surly and unco-operative and  
5 all the rest of it, you can come in and defend that  
6 by either calling her or by cross-examining the Police  
7 or something like that. But where the question arises  
8 as to whether the investigation of the Police was  
9 proper or improper, whether they should or should not  
10 have charged Susan Nelles, I don't know what the  
11 interest of Bertha Bell is, what substantial or direct  
12 interest she has in that matter any more than any  
13 other member of the public.

14 MS. KITELY: Mr. Commissioner, if I  
15 can reply to one of the comments you made that you  
16 don't want to waste time, might I simply say that  
17 during the course of the combined Phase I and Phase II  
18 when certain of the nurses were in that position, we  
19 spent an enormous amount of time about the nurses and  
20 their participation in the Inquiry, it seems to me  
21 if that was a waste of time at that time we ought not  
22 to have been doing it. To the extent that --

23 THE COMMISSIONER: There is something  
24 in what you say.

25 MS. KITELY: It can't therefore be a  
waste of time in Phase II.





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THE COMMISSIONER: Well --

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MS. KITELY: And it would be most  
unfair if the allegations could be made through the  
nurses in their cross-examination.

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THE COMMISSIONER: I don't know why you  
misunderstand me all the time. I am telling you that  
if you are defending your clients you can do that, but  
what I don't want you to do is taking over the reins  
for Susan Nelles and --

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MS. KITELY: I don't think Mr.  
Sopinka would want us to do that. We don't intend to  
do that. But might I reply to the comment that you  
last made?

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THE COMMISSIONER: Yes.

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MS. KITELY: That we might have the  
opportunity to come in and cross-examine. In my  
submission that would be woefully deficient.

The way I would see that working, sir,  
is perhaps - Mrs. Radojewski we know is coming back  
for Phase II because she didn't go into Phase II  
evidence at all - let's say that the Inquiry starts  
into Phase II; we have several weeks of evidence of  
Police Officers who interviewed Mrs. Radojewski. We  
then have Mrs. Radojewski --

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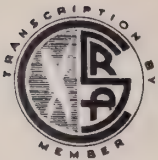
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THE COMMISSIONER: Several weeks fills







me with horror.

MS. KITELY: Days, sir.

THE COMMISSIONER: One day. Several minutes I would say.

MS. KITELY: Would that fill you with horror? We have heard there are a number of officers and two crown attorneys involved in this process.

THE COMMISSIONER: Yes.

MS. KITELY: And I can foresee hearing evidence from those when we are not present, sir, and just using Mrs. Radojewski --

THE COMMISSIONER: I am not suggesting I am sorry, when you are not present?

MS. KITELY: Maybe I misunderstood what your suggestion was about how this would work. The ability to cross-examine; I was assuming that you were giving us just limited standing or considering giving us for purposes of individual witnesses.

THE COMMISSIONER: Well, I would give you standing to your substantial and direct interest, but I don't seem to be able to persuade you as to what your direct and substantial interest is.

Your substantial and direct interest if I understand anything that this thing says is in the reputation, if you like, of your clients. But you





1  
2 have no substantial and direct interest in whether  
3 they should or should not have prosecuted Susan Nelles  
4 or whether they should or should not have investigated  
5 the matter better.

6 MS. KITELY: We --

7 THE COMMISSIONER: Are you with me on  
8 that? Can I ask you that and can I get a direct  
9 answer as to whether you are with me or not?

10 MS. KITELY: I am with you, sir, but  
11 unfortunately I can't agree with you because when we  
12 started out to the extent that these individuals  
13 participated in the process under review, they have  
14 the ability to give information, and the --

15 THE COMMISSIONER: What information  
16 are they going to give? I am sorry.

17 MS. KITELY: We won't know, sir, until  
18 they are called as witnesses.

19 THE COMMISSIONER: Well, what shatters  
20 me about all this thing is that I can't get any  
21 understanding with you at all. I just cannot make  
22 myself clear and I cannot get you to answer any  
23 question I put to you.

24 MS. KITELY: Well --

25 THE COMMISSIONER: Do you want to  
participate in the fight between Susan Nelles and





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the Police?

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MS. KITELY: The difficulty that I  
am having with answering your question, sir --

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THE COMMISSIONER: Well, I guess I  
just can't make myself clear. I can never make myself  
clear.

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MS. KITELY: Well, with the greatest  
of respect, I don't think that's the case, sir.

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THE COMMISSIONER: All right.

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MS. KITELY: We don't want to participate  
to the extent of creating an adversarial situation if  
that is what you are after in terms of the question.

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THE COMMISSIONER: I don't care whether  
it is adversarial or what it is. I just don't see  
your substantial and direct interest in that fight.  
Do you understand?

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MS. KITELY: But Phase II, as I under-  
stand it, sir, is not limited to just the fight, to  
use your words, between Susan Nelles and the Attorney  
General.

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THE COMMISSIONER: Would you like me  
to read the Terms of Reference to you again? Do I  
need to do that?

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MS. KITELY: No, you don't need to do  
that, sir. It encompasses the entire Police

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2 investigation.

3 To the extent that our client  
4 participated in that investigation and to the  
5 extent that they, in the words of the Waste  
6 Management case, have an interest, a substantial  
7 and direct interest and have information that they  
8 can provide, they ought to be defended.

9 One of the difficulties, sir, is that  
10 when Phases I and II were combined for purposes of  
11 these individuals all sorts of suggestions and  
12 allegations were made against our clients.

13 THE COMMISSIONER: What has that got  
14 to do with whether you have standing in Phase II?  
15 It has nothing whatever to do with it.

16 MS. KITELY: If, sir, we had not  
17 combined Phase I and Phase II in my submission, and  
18 if these nurses were unquestionably to be called back,  
19 it is my respectful submission that we wouldn't be in  
20 the position of having to convince you that we ought  
21 to have standing because quite clearly so many of  
22 them would be coming back. We know now that only one  
23 of them is coming back.

24 THE COMMISSIONER: All right.

25 MS. KITELY: You seem to characterize  
"reputation" as a catch-all, and to the extent that





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2 allegations were made against them of lack of co-  
3 operation or whatever, then I suppose that does fall  
4 into reputation and, yes, one of the interests, a  
5 substantial one they have, is that their reputations  
6 be protected.

7 But we spent days and hours, Mr.  
8 Commissioner, of evidence with these very witnesses  
9 in which my friends Mr. Hunt and Mr. Percival were  
10 allowed the opportunity to make suggestions to the  
11 various individuals, and it seems in my submission  
12 only fair and reasonable that when those very same  
13 individuals, the Police Officers or the Crown  
14 Attorneys, whomever they might be, are here before  
15 you and give the very evidence, that the nurses ought  
16 to be represented.

17 THE COMMISSIONER: I am not quarrelling  
18 with that at all. I am just trying to limit you as  
19 to what your participation is going to be and you  
20 won't accept anything I say.

21 If you want to be here to protect your  
22 clients I am all with you. And if you want to be here  
23 to be junior counsel to Mr. Sopinka I don't want you  
24 here at all. Now have I made that position clear?

25 MS. KITELY: I understand and I agree  
with you, sir. However --





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THE COMMISSIONER: Could we stop there?  
Could we just once stop there and then there will be  
a celebration because you and I have agreed on some-  
thing.

MS. KITELY: Well, we can have the  
celebration, sir, but I am afraid it might be pre-  
mature.

THE COMMISSIONER: Yes.

MS. KITELY: Because what I have no  
doubt will happen is that your definition and my  
definition of stopping at being junior counsel to Mr.  
Sopinka will be different.

Now if perhaps it is necessary to  
itemize where that line is drawn, then I am prepared  
to give --

THE COMMISSIONER: We are going to have  
a fight every day, every solitary day on this matter,  
and that is because we can't apparently communicate.

MS. KITELY: Well --

THE COMMISSIONER: If you would just  
tell me what it is you want to do at least I could  
deal with that.

MS. KITELY: Mr. Commissioner, I can  
tell you in basics what we want to do.

THE COMMISSIONER: All right.







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MS. KITELY: We want to be here present for every day of the Inquiry. We want to have the right --

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THE COMMISSIONER: It is a public hearing. You can certainly be here.

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MS. KITELY: At this table with standing, sir.

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THE COMMISSIONER: Yes. All right. And then what?

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MS. KITELY: We want to have the right to cross-examine any witness that reflects directly or indirectly on our clients' evidence before --

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THE COMMISSIONER: Reflects - wait a minute. Directly or indirectly on?

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MS. KITELY: Our clients' evidence that they have already given, or behaviour. We wish to have the right to call witnesses as we did have in Phase I. And just as we had to do --

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THE COMMISSIONER: What would you call them for? What do you have in mind?

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MS. KITELY: Well, Mr. Commissioner, we didn't know when we started --

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THE COMMISSIONER: Call an extra policeman as to how he should conduct an investigation?

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MS. KITELY: We didn't know when we





10 1 started Phase I the answer to that question, and I  
2 can no more given you the answer to that in Phase II,  
3 but that is a right, and I understood you to be asking  
4 me what kind of participation we sought.

5 THE COMMISSIONER: You want the right  
6 to - you want to be able to cross-examine on any  
7 evidence that reflects directly on your clients'  
8 evidence or behaviour. Is that right?

9 MS. KITELY: That's correct.

10 THE COMMISSIONER: And what else do  
11 you want?

12 MS. KITELY: The right to call evidence.

13 THE COMMISSIONER: On what?

14 MS. KITELY: Well, as I say, sir --

15 THE COMMISSIONER: Evidence relating to  
16 what? Evidence relating to the price of eggs in  
17 Peru is not relevant. What evidence do you want to  
18 call?

19 MS. KITELY: All right. If you wish  
20 to try to define that, evidence relating directly or  
21 indirectly to the conduct of our clients and their  
22 evidence.

23 THE COMMISSIONER: All right. Directly  
24 or indirectly on the conduct of your clients in  
25 relation to that particular subject matter, and that





11 1 is --

2 MS. KITELY: Phase II.

3 THE COMMISSIONER: - the investigation  
4 and prosecution.

5 MS. KITELY: Yes.

6 THE COMMISSIONER: Anything else?

7 MS. KITELY: We wish to make submissions  
8 when the time comes.

9 THE COMMISSIONER: All right.

10 MS. KITELY: And if you wish to add  
11 the same qualifications I have no difficulty with that.

12 THE COMMISSIONER: All right. You  
13 want to cross-examine on any evidence which reflects  
14 directly on your clients' evidence or on your clients'  
behaviour?

15 MS. KITELY: Directly or indirectly  
16 I said, sir.

17 THE COMMISSIONER: Directly or  
18 indirectly on your clients' evidence or behaviour.  
19 You wish to call evidence which relates to your clients'  
conduct in relation to the Phase II?

20 MS. KITELY: Directly or indirectly  
21 relates.

22 THE COMMISSIONER: What on earth does  
23 "indirectly" mean?

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2 MS. KITELY: I don't know, sir, but  
3 I know that you are going to hang me on "direct" so  
4 I decided to leave the door open.

5 THE COMMISSIONER: You really must not  
6 say that sort of thing. Now you may think it and you  
7 may say it to your client, but some day you are going  
8 to say it to some judge who, believe it or not there  
9 are some judges who are harder to get along with than  
I am --

10 MS. KITELY: I will remember that, sir.

11 THE COMMISSIONER: - and something  
12 awful is going to happen.

13 MS. KITELY: I understand your interest  
14 in trying to narrow the focus of our position, sir,  
15 but I would ask you to appreciate that since we don't  
16 know what is happening in Phase II we have to allow  
17 ourselves some latitude in approach, and it is for  
that reason that I am suggesting directly or indirectly.

18 THE COMMISSIONER: Well it depends on  
19 how indirectly it is.

20 MS. KITELY: Well --

21 THE COMMISSIONER: Because you can't  
22 get away with that because you can always say that  
something indirectly relates.

23 Really the thing is it is a substantial  
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2 and direct interest in the subject matter, and an  
3 indirect one is not sufficient.

4 MS. KITELY: Could I ask, sir, that  
5 we consider that when it happens?

6 THE COMMISSIONER: I know, but I am  
7 going to make a ruling with respect to your standing.

8 MS. KITELY: Yes, I appreciate that,  
9 but I would ask you to consider if you are considering  
10 qualifications such as what we are now discussing  
11 that we deal with indirect as it happens.

12 THE COMMISSIONER: If you will tell  
13 me what indirectly means then I might consider it,  
14 but the statute says a substantial and direct interest  
15 in the subject matter of the Inquiry, and until you  
16 tell me what indirectly is, I am not going to give  
17 you a right to ask questions on matters that directly  
18 or indirectly - they will have to directly affect  
19 your clients.

20 MS. KITELY: I understand, sir.

21 THE COMMISSIONER: And the same thing  
22 is the evidence that you call will have to directly  
23 affect your clients and the submission you make will  
24 have to directly affect your clients because that is  
25 what the statute says.

MS. KITELY: I understand.





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2 THE COMMISSIONER: Now I would let you  
3 get away with some indirect if you would please tell  
4 me what it is, but if you tell me you can't do it, I  
5 am not going to make that ruling and I am going to  
6 leave it open to anyone any time to cross-examine  
7 any time you lead any evidence as to how this can  
8 directly affect your interest. If it doesn't directly  
9 affect your interest you won't be allowed to proceed.

10 Now that at any rate I have made myself  
11 plain, and are you prepared to live with that or not?

12 MS. KITELY: What I ask, sir, whether  
13 the same kinds of qualifications will be imposed on  
14 the doctors?

15 THE COMMISSIONER: Yes. The doctors  
16 have already offered that. Mr. Ortved said that.

17 MS. KITELY: I didn't understand --

18 THE COMMISSIONER: He wasn't at all  
19 concerned with the Nelles fight. That is why I asked  
20 you - if I could get that undertaking that you weren't  
21 concerned in that, you weren't trying to raise an  
22 issue with the police on one side and the nurses on  
23 the other, I will be happy, but with individuals,  
24 when police make a suggestion that Mrs. Bell didn't  
25 tell everything she should have told, then you have  
a perfect right under those circumstances to







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2 cross-examine. You have a perfect right under those  
3 circumstances to call Mrs. Bell to say I did or I  
4 didn't or why I did or why I didn't, all that sort  
5 of thing if you want to, but that is a direct interest  
6 and not indirect.

7 When you start saying indirect you can  
8 say the whole reputation of the nurses generally are  
9 concerned in this matter.

10 MS. KITELY: Well --

11 THE COMMISSIONER: That the way the  
12 police moved into the Hospital is not proper.

13 MS. KITELY: That of course brings  
14 me to my position with respect to the Association,  
15 sir.

16 THE COMMISSIONER: Yes. All right.

17 MS. KITELY: The Registered Nurses  
18 Association has a variety of objects, and I appreciate  
19 that you have heard them before in Phase I, but allow  
20 me to return to them.

21 They are to promote the stated objects  
22 of the Association which is:

23 "To optimize the effectiveness of  
24 the nurse in contributing to the  
25 quality of life, and to that end;  
to influence positively the quality of





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"practice of nurses;

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to promote and encourage the profession  
of nursing;

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to assist members of the Association in  
matters relating to their practice and  
its environment,

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and to identify and promote the common  
interest of the members of the

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Association."

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Now, to the extent that ultimately in Phase II you might make certain recommendations which affect the way in which health care professionals ought to deal with the police, it will affect, not only the situation that a given Hospital, citing the Hospital for Sick Children, but every other Hospital in this province. To the extent that you make any comments on the way in which certain individuals, who are members of the Association behaved or conducted themselves during the course of the investigation, then that does reflect on other nursing professionals in the way in which they ought to conduct themselves.

THE COMMISSIONER: I don't understand that. I don't understand that at all. If I make comments that the nurses for the Hospital for Sick Children did not co-operate with the police why does that affect nurses of other Hospitals?

MS. KITELY: Because in so doing I would assume, sir --

THE COMMISSIONER: I wouldn't say the nurses generally.

MS. KITELY: You would say Miss Smith.

THE COMMISSIONER: Yes.

MS. KITELY: If you found that Miss Smith did not co-operate because she did A,B and C,







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then we can eliminate A, B and C, then we can eliminate Miss Smith, but surely, the Association is going to be interested in what A, B, and C are, and in promoting to their members, what A, B and C are and how they should be affected in similiar situations.

I think the difference between us, if I might, sir, is that while the Hospital, while this inquiry is related to the Hospital for Sick Children, whatever comes out of this is going to affect more than this given situation, just as the Dubin Report was just an inquiry with respect to the Hospital for Sick Children. It has had repercussions in many other Hospitals.

THE COMMISSIONER: Because, you see, he told the Hospital how they should conduct their affairs generally. If I simply say that it is not very nice for a nurse to clam up and not tell the police, and if that should be the fact, and if I should decide that it is something that I should report on, that applies not just to nurses, it applies to the whole world and the police are investigating what they think is a crime. There are some people who think it would be appropriate to co-operate with the police and there are some people who think they shouldn't, and certainly people who were, themselves, personally





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2 involved it is generally recognized that they don't.  
3 They are under no obligation to co-operate, but  
4 people who are not immediately involved there is an  
5 argument that they should co-operate. Now what has  
6 that got to do with the nurses though? What has that  
7 got to do with the nurses, the Registered Nurses  
8 Association of Ontario?

9 MS. KITELY: Because presumably the  
10 reason why these people are the subject matter of a  
11 discussion is because of their profession. They are  
12 in a position to have information and it is whether,  
13 with that known information, what they do with it  
14 because of their profession.

15 THE COMMISSIONER: It is not because  
16 of their profession, it is because of their job,  
17 because of what they were doing and because they  
18 were there at the time.

19 MS. KITELY: Because of their profession.

20 THE COMMISSIONER: It is not a  
21 professional matter, it is a matter that anyone, who  
22 is present on the scene at the time, and had something  
23 to say, maybe shouldn't have told that to the police.  
24 Maybe they didn't. What has that got to do with the  
25 profession? What has that got to do with the Registered  
Nurses Association?





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MS. KITELY: I keep saying it is and you keep saying it isn't, sir.

THE COMMISSIONER: I am asking you what has that got to do with the Registered Nurses Association?

MS. KITELY: What it has got to do with it is the professional organization wants to see that its members carry on in a professional kind of way and if this inquiry comes up with a conclusion that certain nurses acted in a way which isn't professional then they are going to do something with that recommendation and presumably they will want to act on it. If they haven't been here represented and had an input into the recommendation then it would be most unfair and unfortunate.

THE COMMISSIONER: Yes, all right.

MS. KITELY: Can I say, sir, that while we are seeking standing on behalf of both the professional organization and the individuals, we are particularly concerned about the individuals.

Those are my submissions.

THE COMMISSIONER: Yes. All right, thank you.

Perhaps I should hear from you, Mr. Brown, as to why you want standing.







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MR. BROWN: Mr. Commissioner, I request standing on behalf of Mrs. Trayner with some reluctance. In the first place I know, of course, that you are anxious to see these proceedings streamlined and brought to an end at the earliest possible date. I can assure you that my client would like to see this inquiry brought to an end at the earliest possible date and would like to see herself out of the public eye and back to her chosen profession of nursing as soon as possible. I am concerned that she will remain in the public eye throughout Phase II and that it will be in her interest and, indeed, in the public interest that she have standing during Phase II with the right to counsel and all that entails.

Mr. Commissioner, you will be giving a statement later today with respect to your decision that the argument on Phase I should be in public and your counsel was good enough to release to us a copy of your reasons on that issue and I understand you will be averting to the public nature of this inquiry and the desire to avoid needless damage to individual reputations. That is a desire that all of us share and I know that your counsel share that desire.

In my submission, there is a real risk that my client's name and reputation could be





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2 needlessly and irreparably damaged if she does not have  
3 standing in Phase II and, in my submission, it  
4 was a risk which she should not be expected to take.

5 THE COMMISSIONER: What part do you  
6 anticipate playing, and once again, I put the same  
7 question that I put to Mr. Ortved and Ms. Kitley.  
8 Are you concerned in the fight between Susan Nelles  
and the police?

9 MR. BROWN: The answer to that is  
10 no, but I want to explain my answer to that, Mr. Commissioner  
11 because , with all due respect I do not see Phase  
12 II as simply a fight between counsel for Miss Nelles  
13 and counsel for the police and the Crown Attorneys .

14 As I read your terms of reference with  
15 respect to Phase II, as they have been elaborated  
16 by the Attorney General, it is an unduly narrow  
17 definition of those terms to simply characterise it  
as a fight between Miss Nelles and the police.

18 THE COMMISSIONER: I didn't really --  
19 it is a matter of public interest, of course. Are you  
20 anymore concerned than anyone else in the resolution  
21 of that public concern, and the proper investigation  
22 and prosecution? That is all. Obviously Susan Nelles  
23 is, because she was the person involved and she was  
24 the person who was charged.  
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MR. BROWN: We are concerned about the potential fall out of that inquiry, insofar as it may affect our client's name and reputation. I am not interested in standing behind Mr. Sopinka or, indeed, standing behind the police or the Crown Attorneys and taking one side or the other, but what I am concerned about is that in the course of the evidence dealing with the investigation, dealing with the prosecution, my client's name will inevitably play an important role, and it is my submission, unless we have standing during that Phase of the inquiry, we are not in a position to protect our client's interest and her name.

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I can assure you, Mr. Commissioner, that we have no desire to participate in the cross-examination of witnesses or to call evidence unless it is directly relevant to our client's specific interest and, indeed, I would be happy as can be if we could play a very passive role in Phase II, but I do not see that it would be possible for us to withdraw from the inquiry at this time and to say that Mrs. Trayner has no direct interest in Phase II.

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I think I must, Mr. Commissioner, explain to you, unless I can stop now, that I think that I have to explain to you my reasons for saying







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2 that. In the first place, Mrs. Trayner was an  
3 important witness at the preliminary inquiry. She  
4 gave evidence I think for more days than any other  
5 witness. She gave evidence for six days.

6 THE COMMISSIONER: And Dr. Rowe.

7 MR. BROWN: Even Dr. Rowe. Dr. Rowe  
8 gave more evidence before you in Phase I of this  
9 inquiry than Mrs. Trayner did but I think at the  
10 preliminary Dr. Rowe didn't give anywhere near as much.  
11 Mrs. Trayner gave six days evidence in January of  
12 1982 and she was recalled in April of 1982, with  
13 respect to similiar fact evidence.

14 Secondly, at one stage during the  
15 preliminary, in fact, at a relatively early stage I  
16 think on the fourth or fifth day, the Crown sought  
17 to have Mrs. Trayner declared a hostile witness with  
18 respect to her statement concerning Susan Nelles'  
19 reaction to the Pacsai death and, in fact, His  
20 Honour Judge Vanek directed leave to the Crown to  
21 cross-examine Mrs. Trayner with respect to that  
22 statement and she was, in fact, cross-examined by the  
23 Crown.

24 Thirdly, Mr. Commissioner, Mrs. Trayner  
25 was the object of a number of bizarre incidents which  
we have already canvassed, at least in part, during







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2 Phase I. At the time those bizarre incidents were  
3 raised in Phase I. I think you pointed out that  
4 they were more properly the subject of Phase II what  
5 you allowed evidence to be lead and questions to be  
6 asked on those incidents. I would expect that those  
7 incidents would also be raised in Phase II and would  
8 form a part of Phase II, and, indeed, that there would  
9 be evidence concerning the reaction of the  
10 Metropolitan Toronto Police to those incidents.

11 Now, the second point, and it is a  
12 secondary point, Mr. Commissioner, but I would  
13 expect Mrs. Trayner would be called, as a witness in  
14 Phase II of the inquiry.

15 THE COMMISSIONER: There is no question  
16 that she will be called and she will be represented  
17 by you.

18 MR. BROWN: I appreciate that, but  
19 it seems to me that to properly represent Mrs. Trayner  
20 in Phase II, when she is called as a witness in Phase  
21 II, it would be necessary to have a proper appreciation  
22 of the evidence that has been led into Phase II, so  
23 she can be properly advised with respect to it. It is  
24 a secondary point and I don't think it is nearly as  
25 important as the first point.

The last point, Mr. Commissioner, and





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I know this submission is not going to make you particularly happy, but it seems that I feel that it must be put and I know it supports argument for standing for all the parties that have participated in Phase I and that is this: we have tried in Phase I to separate Phase II evidence and keep it out of Phase I. That hasn't always been possible and to some extent there has been a flow-over of Phase II -- Phase I evidence or Phase II evidence -- into Phase I. I am concerned that there may be evidence in Phase II which goes, not just to the investigation and the prosecution of the charges, but which may also go to how and by what means the children met their deaths.

THE COMMISSIONER: I am concerned about that, too. We have done everything we can do to avoid that. If it happens we may have to call all the people back or either abandon an interest in Phase II or may have standing that has been denied. I don't know what we will do about it. If it happens it happens.

MR. BROWN: Mr. Commissioner, with all due respect, I am not sure that it a risk that we can afford to take, but certainly in my submission a risk that my client should not be required to take and I don't see how you can avoid evidence if it does





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come out in Phase II that is probative to the Phase I issues, how you can possibly ignore it or how you can possibly remedy it after the fact.

THE COMMISSIONER: I can remedy it. That is what the statute is for. The statute says that I will not make any report without giving the person concerned with misconduct, without giving the person concerned an opportunity to attend, cross-examine and give evidence .

MR. BROWN: The damage may be done, Mr. Commissioner, if the evidence comes out in the absence of a person having the opportunity to make an immediate response or indeed to make submissions as to why it shouldn't come out. I know your counsel has been scrupulous in attempting to prevent that sort of thing happening during Phase I and I think by in large we have been successful in doing that, but it seems to me that by granting standing to my client you prevent that very serious risk from occurring in her situation.

THE COMMISSIONER: Thank you. Mr. Labow.

MR. LABOW: Thank you, Mr. Commissioner. Mr. Commissioner, the parents were granted standing in the first Phase and they never had the ability to







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take part fully into the investigation, into the  
deaths of their children and all the other children  
we were looking into.

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We feel that because we are looking into the proceedings and the investigation that arose concerning and after those deaths they should have the same right in the second Phase.

THE COMMISSIONER: Isn't that what Mr. Lamek is here for?

MR. LABOW: No. I think Mr. Lamek is here as your Counsel and to fully represent the public but the parents have a direct and substantial interest into the deaths per se because they were obviously their children.

THE COMMISSIONER: Right.

MR. LABOW: And our submission is that because we are looking into the investigation of those deaths then they still have that same direct and substantial interest.

In February of 1983, the Attorney General addressed the Legislature concerning the Atlanta Report and he said at that time that it was particularly understandable that the parents of the children involved had become frustrated by the lack of a comprehensive explanation.

Now one of the reasons for calling





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2 this commission was to give the parents a  
3 comprehensive explanation, if possible, of  
4 all aspects of why their children died; of  
5 what occurred after their children died; of  
6 what the police did in their investigation;  
7 of what the Crown did when they looked into  
8 it; and of what happened at the prosecution  
9 that was launched due to those deaths. Surely  
10 the parents have a direct and substantial  
11 interest to be here to ensure that they get  
12 as full an explanation with regard to their  
individual concerns in this Phase.

13 The Terms of Reference in  
14 the preamble indicate that there is a view -  
15 that the Cabinet viewed that there was a need  
16 for the parents of the deceased children and  
17 the public to be informed of all available  
18 evidence as to the deaths and the proceedings  
19 arising therefrom. There is no differentiation  
20 in the preamble, the preamble doesn't say, and  
21 the Cabinet did not say that the parents only  
22 had an interest to be informed of all evidence  
23 as to the deaths and therefore should be given  
24 standing; and therefore had a substantial  
25 interest in what occurred, but they also have







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2 an interest in the proceedings that arose  
3 therefrom. When we looked at paragraph three  
4 and were granted standing as to how and  
5 by what means the interest was obvious.

6 It is our submission that  
7 your duty to enquire into, determine and  
8 report on the circumstances surrounding the  
9 investigation and the prosecution that arose  
10 therefrom is just as substantial an interest.  
11 You now have a direction from the Cabinet to  
12 comment fully upon the conduct of any person;  
13 any person during the investigation; any person  
14 who had a part in the institution of the  
15 charges; any person who had a part in the  
16 prosecution of the charges. Now aside from  
17 the Cook family, who I would submit to you  
18 have an even more direct interest, five of  
19 the families that we represent had their  
20 children and the deaths of their children entered  
21 in evidence at the preliminary enquiry as  
22 similiar fact deaths. The Turners, the Lutes,  
23 the Gosselins, the Gionas and Inwoods, all had  
24 their babies deaths put before his Honour Judge  
25 Vanek as a similiar fact death.

Now it is our submission that if





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2 they were used in the prosecution, and they  
3 were, then the parents have a right to know  
4 what kind of investigation was done before those  
5 deaths were mentioned; what kind of enquiries  
6 were made by the Crown Attorney's office and  
7 the Coroner's office and the police, before  
8 they decided to use those deaths as part of this  
9 investigation. They should have a right to  
10 know what was done, as well as what was not  
11 done. The parents are very concerned, in most  
12 cases, that they only learned about the inclusion  
13 of their children in the Nelles preliminary  
14 enquiry after it was concluded, and they want  
15 to know what exactly was done with regard to  
16 their individual children. They also want  
17 to know a number of other things, why other  
18 charges were not laid if the deaths were that  
19 suspicious. They want to know how it developed  
20 that a particular person was charged but no one  
21 else was; or what thought processes were gone  
22 through to charge that person; how complete  
23 was the investigation.

21 THE COMMISSIONER: This is  
22 what concerns me. I know they are concerned  
23 about the investigation, but Phase I, it is the  
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2 cause of death of the children and that of  
3 course is a much different matter, at least to  
4 me it is a much different matter, and the  
5 prosecution for causing the deaths of the  
6 children and the investigation, that is part  
7 of the police process. That is what I am  
8 instructed to investigate and that is what  
9 Mr. Lamek is supposed to be doing and certainly  
10 I would think that Mr. Sopinka has a particular  
11 interest in that matter too. What is the  
12 direct and substantial interest other than  
13 the fact that you represent the parents of  
14 the babies who were the victims of the crime,  
15 if it was a crime? Now is there anything else,  
16 is there anything else other than that?

15 MR. LABOW: The interest is  
16 to find out exactly what was done to look into  
17 those deaths. Mr. Sopinka's interest is to  
18 say, well, why did they charge my client. The  
19 parents interest is the same interest, why did  
20 you charge that person and what did you do  
21 to look into these deaths when the evidence  
22 was fresh. Surely not only what they did, but  
23 when they did it and how they went about it  
24 are important questions for the parents to find  
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F-6

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2 out.

3 Now one of the problems is  
4 that Mr. Lamek, who is Commission Counsel,  
5 represents the public per se, and no doubt  
6 the parents are incorporated within the public,  
7 as is every other person granted standing at  
8 this enquiry. The public encompasses everybody,  
9 but the parents' interest, which I must  
10 demonstrate to you is direct and substantial,  
11 is just that their children's deaths played  
12 such a strong part in this prosecution that  
13 they should have standing to look into those  
14 matters, they should be here to try to help  
15 you to bring out all the facts. Their interest  
16 is much more direct than just the public per  
17 se. Their interest is much more substantial  
18 than just the public per se. If they had  
19 anything to add in Phase I, and it is my  
20 submission that we did have a lot to add in  
21 Phase I in looking at these particular deaths,  
22 we will have the same thing to add in Phase II,  
23 and we have a more focused interest.

24 THE COMMISSIONER: I accept  
25 that, I am not suggesting for a moment that  
it wouldn't be helpful to have you in and







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2 have all the other Counsel in, but there  
3 are problems, there are problems of time and  
4 money and I have to bear that in mind.  
5 Because I could conscript I suppose, if I  
6 wanted to, I could have an advertisement  
7 saying I would like the help of all the Counsel  
8 in Toronto, they would all come and a great  
9 many of them would be of tremendous assistance,  
10 but somewhere around the turn of the century  
11 I hope to be able to sit down and write the  
12 report. Now I am overstating it, and I  
13 will have something to say about overstatement  
14 later on.

14 MR. LABOW: I don't know  
15 if you are overstating it that much, Mr. Commissioner,  
16 I am sure every Counsel in Toronto would love  
17 to be here to try and help you determine this  
18 issue.

18 I think though we have to  
19 focus upon the Public Enquiries Act and what  
20 they call for. If we are calling for a direct  
21 and substantial interest into these particular  
22 Terms of Reference, which I submit was drafted  
23 in order to try to explain the matter to the  
24 parents and the public, specifically to the  
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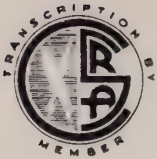


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2 parents, then they must have a direct and  
3 substantial interest in the entire matter  
4 before you, not only Phase I but Phase II as  
5 well. The fact that you can now comment  
6 fully, according to the amendment, makes it  
7 imperative in my view that the parents be  
8 allowed to be here and take full part in order  
9 to bring out anything that can possibly brought  
out.

10 With regard to the Cook  
11 child, his parents have, I would submit, the  
12 most direct interest here as regards to the  
13 parents of any of the children. We have already  
14 heard that the police were on the scene prior  
15 to this child's death, and exactly what was  
16 discussed and what went on and who was contacted,  
17 and what kind of decision was made and why it  
18 was made so that the police did not come,  
19 or were not scheduled to resume their - or  
start their investigation until Monday is of  
20 key interest to Mr. and Mrs. Cook, they want  
21 to know more than anyone else why there was  
22 a delay. Conceivably if the police were on  
23 the scene on Saturday night, their child would  
24 not have died early Sunday morning, and that  
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2 I would submit gives them the most substantial  
3 interest of anyone at this Commission. Surely  
4 the death of their child is more substantial  
5 than why Susan Nelles was charged, and why  
6 that even happened in this situation. But  
7 as regards to the other parents, I would  
8 submit the interest is almost as substantial,  
9 because they want to know how their deaths,  
10 how the deaths of their babies were investigated.

11 THE COMMISSIONER: All right.  
12 Thank you. Mr. Olah I see you are here, are  
13 you seeking standing on Phase II or not?

14 MR. OLAH: Absolutely not,  
15 sir, I am here for submissions on Phase I.

16 THE COMMISSIONER: Yes,  
17 all right, no, that is fine.

18 MR. OLAH: I will be glad  
19 to leave when those submissions are terminated.

20 THE COMMISSIONER: Yes, all  
21 right. Thank you. Who is next? Yes, Mr. Tobias,  
22 are you seeking standing?

23 MR. TOBIAS: Yes, I am,  
24 Mr. Commissioner. Mr. Commissioner, do you  
25 intend to break?

THE COMMISSIONER: Oh --







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2 MR. TOBIAS: I suppose I  
3 could say a few things in a minute and a half,  
4 but it is unlikely.

5 THE COMMISSIONER: We will  
6 have a break. I intend to hear from you,  
7 Mr. Shinehoft and Mr. Shanahan, if he is here,  
8 and then if anyone has any position otherwise.  
9 I am thinking if you have a position with  
10 regard to those who have made application,  
11 all the people who apparently have are going to  
12 have standing and then find out from you, Mr. Lamek,  
13 what representations you have, if any, with  
14 respect to the matter and that I am quite  
15 sure will take us - do you want to start  
16 argument? Then I am going to read this matter,  
17 do you want to start your argument today or  
18 not, I mean this morning, this afternoon.

19 MR. LAMEK: I am perfectly  
20 happy to start this afternoon, sir.

21 THE COMMISSIONER: Well we will  
22 see what it is going to be we may not get  
23 to Phase I argument today but you will be  
24 here in any event.

25 MR. LAMEK: When you say today,  
you mean this morning?





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THE COMMISSIONER: This morning,  
all right 20 minutes.  
--- Short Recess





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2 ---Upon resuming.

3 THE COMMISSIONER: Before anyone gets  
4 too keen on standing let me just tell you what my  
5 plan is which Mr. Percival just got from me in the  
6 hall: as soon as we start on Phase II I intend to  
7 continue throughout the summer. I have to be in  
8 Quebec on business, called the judicial game business  
9 from July 23rd to July, I guess. it is until the following  
10 Monday which is the 30th of July, but other than that  
11 and possibly one other week, if I am pressed hard  
12 enough, we will be sitting throughout the summer  
13 on Phase II and I hope that it will be finished  
14 Labour Day or shortly thereafter. So I don't imagine  
15 that that would have any effect on anybody's  
16 application for standing, but you may just as well  
17 know.

18 MR. YOUNG: Last year we sat three  
19 days a week during the summer. Is that your plan  
20 this year?

21 THE COMMISSIONER: I would like it but  
22 I don't want to force it upon people, but if they  
23 would prefer to sit three days a week, it would  
24 certainly improve my temper.

25 MR. YOUNG: I would move that we  
sit three days a week.





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THE COMMISSIONER: That will probably be what happens but we will sit four days a week until the end of June and thereafter three days a week unless there are some special circumstances or consideration, that there might be a witness that we would have to oblige by sitting on either Monday or Friday.

Now, Mr. Tobias.

MR. TOBIAS: I am applying for standing on behalf of the family of Jordan Hines, and may I start by saying that I adopt much of what Mr. Labow has already indicated to you I do not intend to repeat his point, sir, to belabour it, but there is one point he made that I should say from the outset that I do not adopt, that I will come back to later and deal with later, but I would like to start by talking about what I perceive to be the gut or key issue, and that is the public interest in the circumstances surrounding the investigation of the deaths and the prosecution of the charges as against the parental interest, and whether or not there is really any distinction or difference in those two because I think at the end of the day when we analyse the question that is really what it comes down to, and I think the standing of other parties can be analysed







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along much the same lines, and particularly the doctors  
and the nurses.

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May I start by saying this, that as  
I interpret the words "substantial and direct  
interest" that are used in the legislation, it seems  
to me that when determining whether one has an  
interest, what you are really looking at is the  
effect that the events being inquired into have or  
had upon that person and their rights and their life.

If they have no effect whatsoever,  
then clearly that party is not an interested party,  
and if you look at the three main players in this  
scenario, and I would submit to you that they are  
the Crown Attorneys and the Coroners, and the  
Metropolitan Toronto Police and Nurse Nelles, that  
principle is clearly reflected, because after  
all the fact is that the actions of the police and  
the Crown had a very dramatic impact and effect upon  
the life of Nurse Nelles and upon her rights. And if  
it weren't for that effect and if it weren't for that  
impact then clearly she wouldn't have an interest  
either and she wouldn't have standing. And the same  
could be said of the other two players.

The life of the institutions, the  
Attorney General's Office and the Metropolitan Toronto





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Police Force - and make no mistake about it, institutions have a life - the events into which you are inquiring have and had an effect upon the life of those institutions and anything that you might say about their conduct might have an effect. So if we are looking at interest my submission is we have to look at how do the events affect the players.

Now with respect to the public there is no question that the public has a great concern dealing with the investigation and the prosecution of charges. But in fairness I think the point is that the public concern, albeit a legitimate concern, is basically an abstract concern, and the public is interested in what happened essentially as an abstraction.

It is in a very, very broad sense that they are looking at the administration of justice, what was done and what wasn't done, were the duties that we entrust to the police and the Crown honoured? Did they do a good job? Could they have done more? Should they have done more on the one hand?

And on the other hand they look at the actions of those institutions as they affect the life of the individual involved. And then thirdly they look at the actions in terms of were the actions





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appropriate in accomplishing an accounting because we are very concerned if someone was harming babies that that person be brought to justice.

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But again I point out that the public perception and the public interest is very much an abstraction. And now I would like you to look specifically at the Hines family and at all the families because their interest I say to you in the first hand, and this is a major distinction, is far more than an abstraction.

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The fact is that they are entitled to know what was done in terms of looking into all of these deaths, into the whole series of deaths because they are the victims, and if the investigation does not handle it properly, if it was botched, then it may very well be that a perpetrator of harm to those babies may go without the kind of public accounting that I am talking about.

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But you see they are not affected by that just in the abstract in the sense that justice is not done. The events that occurred at that Hospital and the events which occurred after the deaths affect their life in a very, very direct and very real way. It affects them day to day. It is something that is constantly in their minds. It is something that is







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going to be in their mind every time they deal with those institutions because once burned forever forewarned. And in that sense they are interested not in an abstract sense at all, but in a very direct way.

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What you determine in terms of how the investigation of the death of their baby was handled will affect them directly and it will affect the course of their life. It will affect them as human beings, and I think that is a major distinction which I wish to draw.

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Now it has been said that in fairness you are represented by very able counsel and that surely that counsel helps protect the public interest, and that is true. I do not challenge that. I do not challenge that at all.

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However, I think again we have to draw a line, and it may be a very fine line, a very difficult one to make, but it is critical that we draw it, is that what your counsel are representing is that abstraction, that abstract general public interest. They cannot possibly do a good job representing the greater and more direct interest with respect to all 36 sets of parents. It is an impossibility. They simply cannot deal with it that





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2 directly on a child by child basis. Otherwise, sir,  
3 you will be here until the turn of the century.

4 Now, to an extent the role of the  
5 doctors and the nurses and I would say even to an  
6 extent the role of the Hospital itself are subsumed  
7 in the public interest. You have two sets of players  
8 here. You have the actors. Now the actors were the  
9 police and the Crown. Those are the institutions  
10 that did or did not do something. Everyone else,  
11 Miss Nelles, Mrs. Trayner, the doctors, the nurses,  
12 the Hospital and the parents were only affected  
parties.

13 They didn't undertake the investigation.  
14 They didn't perform the investigation. And what I  
15 see happening is that each one of those groups of  
16 people have some sort of very special direct and  
substantial, albeit limited, interest.

17 You have asked other counsel this  
18 morning were they concerned at all with respect to  
19 the fight between Nelles and the police. And I  
20 adopt Mr. Strathy's submission. I don't think it  
21 is that narrow. However, I will come to that in a  
22 moment. I would like to respond on behalf of the  
23 Hines family in this way: we are certainly not  
24 interested whatsoever in that fight in any direct  
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2 and substantial manner.

3 The fact is that both the police and  
4 Miss Nelles are represented by extremely able counsel.  
5 They hardly need the help of any other counsel. So  
6 our interest in that fight is a very limited interest.  
7 We are only interested in it to the extent that it  
8 reflects directly upon and in like regard with respect  
9 to what was done or not done or what should have been  
10 done in respect to their investigation of the Hines  
11 child only, and it seems to me that if we are perhaps  
12 granting standing it has got to be under those ground rules  
13 because that is the only thing that affects the  
14 very direct interest that I have been talking about.

15 If, Mr. Commissioner, you intepret  
16 the terms of reference, and it is up to you to  
17 interpret them, very narrowly, then I think that  
18 certainly the parents and probably the doctors and  
19 the nurses as well have an extremely tough road to  
20 hoe in convincing you that they have any interest  
21 at all let alone a direct and substantial interest.  
22 And by direct and narrow I mean if it is your view  
23 that you are looking at the investigation and  
24 prosecution as it relates only to the four deaths,  
25 then I think that is the end of the debate. It is  
finished right there. I have nothing further to say.







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However, I think, sir, that that would be an incorrect interpretation for you to place on the terms of reference because it seems to me that you can't narrowly read the words in paragraph four. You have to give them a broad interpretation and you have got to relate them back to the words in the preamble, and as I read the pre-amble- there are a number of phrases, sir, I wish to bring to your attention - in the very first circumstance the Attorney General or the Lieutenant Governor in Council talk about a number of deaths occurring between July 1st, 1980 and March 31st, 1981.

He doesn't talk about Cook, Miller, Estrella and Pacsai. He talks about all the deaths, all 36 occurring in that time frame.

THE COMMISSIONER: Didn't we have this out, though, when we discussed the extent of Phase II as to whether we would go beyond the discharge of Susan Nelles in the inquiry, and we decided then the deaths of the above mentioned four infants did govern.

MR. TOBIAS: I hope that that was merely a collateral point discussed within the context of only to what point in time your inquiry goes.

If I misunderstood, if you took that as







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being a decision on the whole scope of Phase II -

THE COMMISSIONER: No, no, but obviously the investigation, the deaths and the prosecution of charges arising out of deaths of the above mentioned four infants - now that you can still take under consideration of course the deaths of the other children. That might well be a matter that one would be interested in before laying charges arising out of the deaths of the four infants, but it is only the four infants that are directly involved in the circumstances surrounding the institution of criminal charges.

MR. TOBIAS: Mr. Commissioner, with respect I would urge upon you another interpretation if you will humour me just for another few minutes.

THE COMMISSIONER: All right.

MR. TOBIAS: Because I would rather deal with all of the things that precede those words because I think that they help you interpret those words.

Now in particular I have already referred to paragraph one. Paragraph two I think is very clear in that it says that concern has been expressed regarding the functioning of the justice system in respect of the instituting and prosecuting





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of charges in relation to the said deaths. Now he can only be referring to the deaths he has already referred to in paragraph one which are all the deaths .

Mr. Labow pointed out to you and I think that on page one of the terms these are probably the key words, that there is a need for the parents of the deceased children, and I think it is worthy to note that he has specified parents - he separated them out of the public domain and thought they were worthy of specific mention - for the parents of the deceased children and the public as a whole to be informed of all available evidence as to the deaths, again referring to all 36, and the proceedings arising therefrom..

Now those words are interesting. Proceedings arising therefrom clearly relates to the charges against Susan Nelles which coincidentally it is true related only to four infants.

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2 But it was all 36 which gave rise to those four  
3 charges and it was an investigation in a global  
4 sense of all 36 which led to the delay of those four  
5 charges. The fact that similar fact evidence was  
6 led, with respect to a great number of these infants,  
7 Hines included, indicates that they had to have been  
8 part of the investigation, which raises a very  
9 interesting question: certainly one of the things  
10 that you are going to be looking at, and I think your  
11 words were this morning to Miss Kitley: Is she  
12 interested in whether or not they should have  
13 investigated the matter better? Well, there is  
14 a strong argument to be made, depending on what comes  
15 out in the evidence, and I have no pre-conceived  
16 position or notions about it, but there is a strong  
17 argument to be made that if the investigation had  
18 been handled differently, if it had been a longer  
19 investigation, if it had been a more thorough  
20 investigation, we may very well have had more than  
21 four charges, with a different result at prosecution.  
22 So that is clearly one of the questions that you have  
23 been looking at.

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25 Now, when we get to paragraph four,  
the way I read paragraph four is this: The last four  
words --







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2 THE COMMISSIONER: Just a minute, Mr.  
3 Tobias. There may be something about a small room  
4 that makes it easier for me to see what is going on.  
5 I consider it is exceedingly poor manners for somebody  
6 to be reading a newspaper in the place of argument.  
7 Obviously the article is so engrossing that --  
8 All right, Mr. Tobias.

9 MR. TOBIAS: I don't mean to forgive  
10 the transgression, but the man probably thinks the  
11 newspaper is far more interesting than my argument  
12 and I dare say he is probably right.

13 THE COMMISSIONER: I am not prepared  
14 to pronounce on that matter at all. I was pronouncing  
15 only on manners and I don't mean that seriously.

16 MR. TOBIAS: When we get to the last  
17 six words of the above mentioned four incidences  
18 taking into account everything I have said up until  
19 now about the specific wording used in the preamble,  
20 what I am saying is this: I don't think those words  
21 are meant to limit or constrict your interpretation  
22 of all of the foregoing. I think they are descriptive  
23 words only, indicating specifically what charges he  
24 is referring to and clearly they are charges relating  
25 to those four particular infants, because those were  
the only four charges laid, but to read those words,





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2 as indicated, that the scope of your Inquiry is only  
3 with respect to the investigation of those four  
4 deaths, which led to the laying of charges, I think  
5 is to put far too narrow of an interpretation on it,  
6 because if we are looking at the investigation I say  
7 that we have to look at the investigation globally,  
8 otherwise it doesn't make any sense whatsoever.  
9 You can't dissect part of it out and say that we are  
10 going to enquire about that particular aspect, but not  
11 others.

12 Because of that I would argue, and this  
13 is the part of Mr. Labow's submission, that I can't  
14 in conscience accept. I would argue that theoretically  
15 all three sets of parents, each and every last one  
16 of them, have a direct and a substantial interest in  
17 the questions concerning the investigation of their  
18 child's death. It would be the easiest thing in the  
19 world to put them into some sort of hierarchy or  
20 characterize them. You could say, well, the most  
21 direct interest is obviously "Miller, Pacsai and  
22 Estrella" and after that the second most direct interest  
23 is all of the children wherein similar fact evidence  
24 was led and somewhere at the tail end you have the  
25 others.

Let's look at it from the point of





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2 view of those parents whose children did not form the  
3 substance of the charges and who were not even  
4 introduced at the preliminary in similar fact evidence.  
5 Are we telling them they have any less interest in  
6 knowing what was done, in order to find out how their  
7 baby died? Perhaps they may, in fact, have the most  
8 to complain about, because they may, at the end of the  
9 day, be the ones who are saying "If you had only  
10 looked, if you had only paid more attention, if you  
11 had only been more thorough we would have been part  
12 of those charges." So I clearly reject any attempt  
13 whatsoever to somehow distinguish between the groups.  
14 I think they all have an interest.

15 I might also point out, with respect to  
16 the Hines family, in particular, and having said  
17 that everyone has got to be treated on the same  
18 footing and that we shouldn't characterize the families,  
19 I have to step back from that just for a second. It  
20 is a small point, but a point that I think is important  
21 to make.

22 I said earlier that all of the parents  
23 have a very direct and not an abstract interest and  
24 how they deal with these institutions in the future,  
25 at least the Crown, but we also have to remember part  
of your deliberations, you can't get away from it.







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2 You are going to be looking at the Hospital, at the  
3 Hospital Administration, at the doctors, at the  
4 questions of were they asked to co-operate, did they  
5 co-operate, did they do everything they could to give  
6 us a fair chance to find the answers here.

7 I would like to remind you, sir, that  
8 my clients still have a child whose care they entrusted  
9 to that institution on a regular basis.

10 THE COMMISSIONER: I know, but that,  
11 Mr. Tobias, that argument simply isn't available to  
12 you. I don't know how many patients in the Hospital  
13 there are now and all of those people would have as  
14 much interest as your client.

15 MR. TOBIAS: I recognize that, sir,  
16 but it is a horrible thing to say really and it is  
17 an unfortunate and a cruel term of circumstances that  
18 those people can't come here and ask for standing.  
19 Thank God their children didn't die. I would think  
20 they are ecstatic that they don't have standing.

21 THE COMMISSIONER: The point I am  
22 making on that argument of yours is they have as  
23 much right of standing as your clients.

24 MR. TOBIAS: They fall somewhere in  
25 between, the abstract interest only and the very  
direct and substantial interest that I have been







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2 talking about. You can't say their interest is only  
3 abstract, but it is a collateral point. I am not  
4 pursuing it. I think it is important that you under-  
5 stand it and that you understand what I am saying to  
6 you.

7 THE COMMISSIONER: Isn't there a  
8 difference between Phase I and Phase II? Phase I  
9 is what happened to their children. They have a  
10 direct interest and a very particular interest in  
11 what happened to their children and a question of what  
12 happens after is no more than the interest that any  
13 victim has in any, if there is a crime, in any crime  
14 that is committed.

15 MR. TOBIAS: Let me approach it this  
16 way: I think where you err, sir, with great respect,  
17 is in assuming that all that happened to the child  
18 was that the child died. Something more than that  
19 happened to the child. The child died in circum-  
20 stances where, for one reason or another three years  
21 down the road, no one has provided an answer, no one  
22 has provided accountability. That may just be the  
23 circumstances of the case. It might defy our Lord,  
24 himself, to answer these questions, however, the point  
25 is that it may very well be that those who are in  
charge of seeing that perpetrators of wrongful acts





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are punished may have been errors in judgment, which led to that end result. I say that the fact that they haven't been given the answers and the fact that no one has been brought to justice is as much a part of the event as the death itself. I don't think you can distinguish the two. I don't think you can cut it off at saying your interest only goes to whether or not your baby was murdered, and that is the end of the equation, and you have no interest beyond that. Surely they have a very direct interest in what was done about the fact that the baby was murdered. Surely that is different than the man in the street. That is why in our profession now we are engaged in a great debate about the role in the victim -- of the victim, rather -- in the justice system and whether or not the victim should be able to address the tribunal, the trier of fact.

I think there is a distinction there and I think that it is exceedingly important for you, it is probably more important for you to recognize that distinction than for anyone else for this reason: Mr. Scott once urged upon you, and I think he was entirely right, whether or not your report is a good report is only half of the problem. It may be that the very best report that you, with your considerable





talents are able to bring to bear, but if it is not perceived by the public to be the result of fair and completely open and full deliberation then, although it may be an excellent report, it will all be for naught, because it just won't have the kind of public acceptance that every single person in this room hopes that it will have, and I think that the difficulty is this. It is very difficult to give that perception of openness and fairness and stress these words "Fulness and completeness" if you exclude from the deliberations in Phase II those people who, unquestionably were most directly affected by those particular events.

It is because of the critical nature of that public perception that we cannot simply afford to say in an open and public forum, well, I am sorry, we would like to give you the chance to participate, but time doesn't allow. If I may say a word in your defence, sir, although I hardly think you need my defence, but an awful lot has been said about how long the process has been: "My goodness, it's been a year. Isn't that extraordinary?" But I think what all too often the media and the public forget is how complex a task it is. In the end the fact that it went a year may be something very much in your favour.







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2 It may have gone on a lot longer had  
3 you lost control of it or not conducted it in the  
4 manner in which you have, but I simply don't think  
5 that we can allow considerations of time and stream-  
6 lining to shut out these people. I think that is just  
7 as important as the point I opened with, sir.

8 Thank you.

9 THE COMMISSIONER: Thank you.

10 Mr. Shanahan.

11 MR. SHANAHAN: I'm going to let Mr.  
12 Shinehoft --

13 THE COMMISSIONER: Mr. Shinehoft.

14 MR. SHINEHOFT: Mr. Commissioner, I am  
15 going to make one or two general comments about  
16 parents' counsel and then I am going to make a couple  
17 of specific comments about Kevin Pacsai and the role  
18 he has played in Phase I and what role he may play  
19 in Phase II.

20 As pointed out by Mr. Labow and Mr.  
21 Tobias, I think it is important that you look at the  
22 Terms of Reference in the Order-in-Council, at the  
23 specific wording. I don't want to belabour the  
24 point, but in the third paragraph it talks about:

25 "Whereas the Government of Ontario is  
of the view that there is a need for





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"the parents of the deceased children  
and the public as a whole to be informed  
of all available evidence, as to their  
deaths and the proceedings arising  
therefrom."

It would seem to me that if the parents  
were to be informed of that the Lieutenant Governor  
could have put "and the public, the proceedings arising  
therefrom."

So both the public and the parents are  
included in the latter part of that sentence and it is  
conjunctive, as opposed to disjunctive. I just point  
that out. It may assist you in interpreting what  
exactly the Order-in-Council meant.

From a parents' perspective, Mr.  
Commissioner, I think there is a difference between  
your ability to name names and your ability not to  
name names. I mean it in this context: If names were  
named and you indicated that Baby A died, as a result  
of a deliberate overdose of digoxin administered by  
person B, and if the parents felt grieved about the  
situation they could make representations to the  
Attorney General, they could make representations to  
the Police and they would have certain avenues avail-  
able to them, however, but by not naming names they





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don't have any recourse.

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You are entitled to characterize the  
act as an intentional deliberate overdose of digoxin.  
Some people suggest you could even call it murder.

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We know that Susan Nelles was arrested and discharged at the preliminary hearing. What position does that leave the parents in? Surely they should be entitled to be involved in the investigation as to what happened, what went wrong if anything.

THE COMMISSIONER: I am having some trouble with that. The parents, it wouldn't make any difference whether I name names or not as to what the parents rights are. If I were to say that in my view some of these children died of a deliberate overdose of digoxin, would the parents not have a perfect right to say to the Attorney General what are you going to do about it?

MR. SHINEHOFT: I am saying on top of that they are entitled to be involved in the investigation as to what happened, did something go awry, was the police investigation properly conducted or was it improperly conducted. If you were to say, as I have said previously, that a certain individual was involved, I take the position that the parents would have less of an interest to be involved in Phase II than







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2 if you were not naming names.

3 THE COMMISSIONER: We are  
4 not going into Phase II, we are not in any  
5 way going into identity of whoever it was,  
6 we can't do that.

7 MR. SHINEHOFT: I appreciate  
8 that, but we are going to be involved in the  
9 police investigation and the conduct of the  
10 police and whether it was a proper investigation,  
11 and whether it was not; if something went wrong,  
12 what went wrong and why it went wrong. That  
13 Mr. Commissioner, as I perceive it, is the  
14 pith and substance of Phase II. I say that  
15 just as a preliminary matter, I think there  
16 is a difference between naming names and not  
17 being able to name names.

18 Now the four children with  
19 whom Susan Nelles was charged with Murder,  
20 namely Cook, Miller, Estrella and Pacsai, and  
21 again the reference is made in the Order in  
22 Counsel specifically to those four children,  
23 and at page 2, paragraph 4:

24 " To enquire into, determine and  
25 report on the circumstances  
surrounding the investigation,





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institution and prosecution  
of charges arising out of  
the deaths of the above-  
mentioned four infants. "

In that respect I guess my position is a  
little different than the other Counsel save  
and except perhaps my friend Mr. Labow, who  
I did not know until this morning has been  
engaged to represent --

THE COMMISSIONER: I'm not  
sure that he did either.

MR. SHINEHOFT: ...the Cook  
family. But here you have four children, four  
deaths which is the critical deaths, if I can  
put it that way, that gave rise to a police  
investigation. My clients were interviewed  
by the police and they may be very well giving  
evidence in Phase II.

THE COMMISSIONER: There  
is no question whatever if they do give  
evidence that you will represent them at  
that time.

MR. SHINEHOFT: As I think  
was fairly point out by Mr. Strathy, I think it  
is one thing to be here to understand the





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evidence that is being introduced, to understand or comprehend the way the evidence is going in, and then to be catapulted in one day, you get phone call your clients are going to be here and they are going to give evidence. With the greatest of respect I adopt that position by Mr. Strathy, I think there is a difference between the two. So they were interviewed by the police, there is no question about it and they may very well be called as witnesses. There is no question that that death was if not the, one of the critical deaths that precipitated this whole thing. It was the chance meeting between the two pathologists, Dr. Cutz, and I'm trying to think of the name of the pathologist that performed the autopsy on Estrella, Mancer I believe his name is, where they offhandedly discussed digoxin levels and then from there they went to Dr. Ellis' office to ascertain the validity of the testing methodology, and then from Dr. Ellis' office the phone call was made to the police, and this is what precipitated the entire police investigation, Mr. Commissioner. So I don't have to overstate the importance of Pacsai,







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2 I believe you have heard all the evidence and  
3 you know what this child's involvement has  
4 been in the proceedings. All I say is two  
5 things. I say that first of all, all parents'  
6 Counsel should be granted standing to the  
7 second part, but I would say that my position  
8 is a little different than the rest of them,  
9 if you were to consider granting standing  
10 to only one of the Counsel, and those are  
my submissions.

11 THE COMMISSIONER: Thank you.  
12 Mr. Shanahan?

13 MR. SHANAHAN: Yes sir,  
14 Mr. Commissioner. I am aware of a lot that  
15 has gone before. I might say at the outset,  
16 Mr. Commissioner, that this issue of standing  
17 on Phase II that I have -as I think it is  
18 my responsibility, I have discussed it with  
19 both of my clients, the Dawson family and the  
20 Lombardo family too, to have their input here  
21 so that they would know precisely what my  
22 submissions would be and my submissions  
23 would be based upon their real and genuine  
24 concern in the matter here.

25 I might say I have canvassed





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as best I could in layman's terms what has been accomplished in Phase I and what the corollary Terms of Reference were in what we are heading into in Phase II.

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I would like to say that the position I take here today, sir, is the position not just taken by myself and my own clients, as I represent, sir, their direct and implicit instructions with respect to what they perceive Phase II will cover and what interest they might have in it.

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I might say, sir, I am concerned I suppose on the one side there is - there can be drafted an argument here, emotionally or intellectually if you like, as to the input the parents should have and why they should be here. I might say if it is perceived on your part you see a limiting factor in that Terms of Reference, the Terms of Reference might fairly exclude some families.

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If I could really - insofar as I have adopted much of what has gone before me that I have heard this morning, if I might more specifically refer you to the two





I-7

1  
2 families that I represent here, sir. Many  
3 parents here have been made aware of the  
4 fact there was a Royal Commission going to  
5 be investigating the number of deaths. Many  
6 of the families for reasons best known to  
7 themselves have never participated, and I  
8 don't know what input they had with the  
9 police, but many certainly have not seen  
10 fit to obtain Counsel and instruct Counsel to be here and  
11 I am sure they have their own personal reasons.  
12 Both families that I do represent here, sir,  
13 have been here represented by Counsel through  
14 Phase I. I might say even before I came on  
15 the scene quite clearly both the Dawson  
16 and the Lombardo family have been vitally  
17 concerned about the things that happened.

18 If I may refer you more  
19 specifically to Mrs. Dawson, it is quite  
20 clear that the death of the Dawson child caused  
21 tremendous concern within the Hospital itself,  
22 and the independent record keeping and note-taking that  
23 we have from those times and the communication  
24 books and ward books, quite clearly set out  
25 well into March in fact into July, long before  
March, that in fact there was a concern here with







I-8

1  
2 the Hospital staff and the doctors about the  
3 child's sudden and unexplainable death. Then, sir,  
4 you have the mother's concern as well. That is  
5 indicated in all the evidence from Nurse Nelles  
6 and Trayner here, tremendously concerned, having  
7 the wherewithall and insight, or the level  
8 of suspicion to be concerned that her child  
9 had not died from natural causes. You have  
10 heard, sir, the evidence that in fact this  
11 was carried through. All agreed she wanted  
12 an outside pathologist and she carried that  
13 through, had a meeting with Dr. Bunt and  
14 accepted Dr. Bunt's evidence, for the sake of  
15 argument here this morning as being a proper  
16 and more accurate accounting of it. She  
17 mentioned to him her concern about medication.  
18 You have this lady as well, sir, attending  
19 from out of town to give evidence here at  
20 this Royal Commission. Again someone chosen  
21 not to be represented and even those that  
22 have been represented have not availed  
23 themselves of the opportunity to give any  
24 evidence here, and, as I say I am sure for  
25 their own reasons. She has come at great  
considerable personal expense, to come here and







I-9

1  
2 give her evidence and you heard the evidence  
3 that she gave.

4 I can assure you, sir, if  
5 it is any indication, or any merit, or in  
6 any way affects how direct and substantial  
7 her interest might be, I can assure you, sir,  
8 she is vitally concerned in the subject matter  
9 of Phase II.

10 Again, sir, not to be  
11 casting about here in any way, shape or form  
12 for people who may not have, come up to standard  
13 of care or duties or obligations, her  
14 matter, sir, is to see through once and for  
15 all to see the events through from A to Z.

16 I might say, sir, relating  
17 it to the Lombardo family, again a family who  
18 perhaps at the time did not express the  
19 level of suspicion that Mrs. Dawson expressed  
20 but certainly a concern harboured in their  
21 own mind and concern that their child had  
22 died an unnatural death. That in fact during  
23 the course of the Nelles enquiry in which they  
24 took a great interest of their own accord and  
25 following and then to realize that their child  
as a result of an Order was exhumed. That





I-10

1  
2 child was exhumed in the hope of fitting  
3 it into a similiar pattern of similiar fact  
4 evidence, and lo' and behold for that child  
5 Nurse Nelles was not present, and that baby  
6 has died at a very quiet time of the year, and  
7 in fact there are substantial digoxin readings  
8 in her system and the tissues.

9 Again, sir, people here  
10 who are very concerned knowing perhaps their  
11 child is the pivotal baby in terms of leading  
12 to the discharge of Nurse Nelles and also  
13 aware of the fact that Nurse Nelles is  
14 discharged and mindful of this Commission  
15 and anticipating fully in this Commission.

16 Mr. Scott made, in terms  
17 of his submissions as to the recent Court of  
18 Appeal ruling, he used the metaphor of this  
19 Commission perhaps being a window on events  
20 for the parents here and leading perhaps  
21 ultimately to a source of reconciliation.  
22 These families here, I might say none of my parents,  
23 none of the families that I act on behalf  
24 of, are litigating here or even contemplating  
25 any litigation. This Commission is going to  
be the last word for them. What they see and





I-11

1  
2 hear through here will be what they have  
3 to carry forward into the future as to what  
4 in fact happened to their child and how those  
5 deaths were investigated.

6 If in fact it is to be a  
7 window on events, not just the events up  
8 to this point in time, which they are grateful for and  
9 they don't feel there has been any undue limitation as  
10 to how the child died, what then we as  
11 a society at large and the investigative  
12 tools we have at our disposal, what society  
13 at large did to follow-up, especially when  
14 you say on the suspicion of somebody like  
15 Mrs. Dawson, they certainly are of concern  
16 and interested in and wish to participate in  
17 that discussion of that investigation. I  
18 might say to emphasize Mr. Scott's position,  
19 what comes forward will be what they will  
20 be left with in terms of reaching that ultimate  
21 conciliation in their own mind to resolving  
22 that and putting those events behind them once  
23 and for all.

24 It is an error, sir, to pick  
25 up on a point of Mr. Tobias, it is an error when  
the Courts found for better or for worse and







I-12

1  
2 with all the difficulties that have ensued  
3 from it, our having victims as they are  
4 called, victims having an input into the  
5 judicial processes. This really, sir, is  
6 even broader based than the judicial process,  
7 we are not looking for someone to have a  
8 sentence that reflects perhaps the degree  
9 of occurrence and concern in the victim's  
10 life. We are here simply to investigate  
11 a broader - the Commission is much more  
12 broadly based on the rules of evidence and  
13 what we can hear. Now you are hearing more  
14 really than a victim, I don't think the parents  
15 would want to be called victims, at least those  
16 that I act for. We are here for the  
17 direct families who had a concern about  
18 their health, not so much a victim of a crime,  
19 but the health and the care of the children  
20 in the custody of the Hospital that is  
21 committed to that care and those children coming  
22 to perhaps an untimely death. I am suggesting  
23 that we won't call them victims, but if  
24 you wanted to draw a parallel to the type  
25 of rights and the types of participation the  
victims have within the judicial process and I





I-13

1  
2 am suggesting to you as well, sir, that the  
3 parents' input here and the presentation and  
4 their presence here.

5 Finally, sir, the public  
6 perception, the perception of their input  
7 and the public perception of the time this  
8 Commission has gone on. With the greatest  
9 of respect, sir, I don't put forward that I  
10 read the public sentiment any differently  
11 than you. In my submission, to you sir, I  
12 don't think at this juncture the Commission  
13 having gone as long as it has, Phase II  
14 hopefully being as short as it may well be,  
15 the public would say that parents of children,  
16 specifically the parents if they knew the  
17 position of Mrs. Dawson, if they knew the  
18 position of Mr. and Mrs. Lombardo; if they  
19 knew what they have been through, if they knew  
20 the input they have had; the exhumation on  
21 the one hand and Mrs. Dawson's own suspicions  
22 and carrying them forward. If they knew all  
23 that we know and were not dependent on the  
24 media of simply what their perception of this  
25 Commission was, with the greatest of respect,  
sir, I submit to you that they would have no  
quibble about saying those parents of 36 that





I-14

1  
2 participated; those that participated also  
3 that had some input here, to say to them, yes,  
4 you can continue forward, and neither in  
5 terms of time or expense the public would  
6 object at all. I would submit to you, sir,  
7 quite the converse, if the public knew the facts  
8 and stood in the shoes of those people whom  
9 I represent that in fact what they would say  
10 is there really is not only emotionally or  
11 academically, or in the abstract, a right to  
12 be expanded upon about being here, for them  
13 to be here and see this matter through  
14 once and for all that they could put those  
15 matters behind them, I think the public, sir,  
16 would be behind it.

17 If you think, sir, that  
18 the frame of the Terms of Reference are too  
19 narrow; if you feel, sir, that it is a political  
20 decision that is required to expand them to  
21 allow you to permit the parents to be here,  
22 I ask you sir to seek that political approval  
23 and that, sir, you do get the authorization to  
24 allow the parents in this last end stages  
25 of this Commission, to allow the parents to  
be here to see how those citizens that were





I-15

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perhaps murdered, how their deaths were  
investigated and the results that investigation  
led to.

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THE COMMISSIONER: Thank you.

6

Miss Thomson, have you anything to say with  
respect, not to your own position, but with  
respect to those others who have applied for  
standing?

8

9

MS. THOMSON: No, sir, I

10

don't think I can assist you any further.

11

THE COMMISSIONER: Mr. Brown,

12

have you anything further?

13

MR. BROWN: Yes, I do, sir.

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THE COMMISSIONER: Fine.

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J-1 1

EMT/hr 2

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MR. BROWN: Sir, in respect to the application for standing by the doctors and the Registered Nurses (not the Association but the individual nurses) I would support their application for standing to the extent that they be allowed to participate when, for example, one of their clients is called to testify before this inquiry, and secondly if evidence is led through another witness, if allegations are made through another witness with respect to any of the individuals, be they nurses or doctors, that the counsel for the nurses and the counsel for the doctors be entitled to cross-examine and to call evidence if necessary with respect to those allegations.

With respect to Mr. Strathy's application on behalf of Mrs. Trayner I suppose on that basis I would also have to support it since there might well be allegations made and questions of reputation involved which would necessitate either his cross-examination or examination of his own client or the cross-examination of some other witness.

With respect to the application by counsel for the parents, we oppose their application for standing. We oppose it not on the basis that the terms of reference preclude you from considering the





J-2

1  
2 investigation of children other than the ones that  
3 Miss Nelles was charged with. We take the position,  
4 sir, that the terms of reference should not be so read  
5 It is very true that you are to look into the  
6 investigation and the prosecution of Miss Nelles with  
7 respect to the deaths of four specific children.  
8 However, sir, during the course of that investigation  
9 and prosecution other children were considered and  
10 as Mr. Shanahan has indicated to you one of them,  
11 the Baby Lombardo, played a very important role  
12 leading to the discharge of Miss Nelles. So to a  
13 certain extent other children will be canvassed and  
14 I believe the terms of reference support that  
15 interpretation, sir.

16 We oppose the application by the parents,  
17 however, on the basis that they do not have a  
18 substantial and direct interest in the subject matter  
19 that requires them to be represented by separate  
20 counsel.

21 We take the position, sir, that their  
22 interests can be adequately represented by Commission  
23 Counsel. We acknowledge that the parents of these  
24 children do stand in a different position to some  
25 degree from any member of the public since some of  
the children may be considered victims of crime.





J-3

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Notwithstanding that we take the position, sir, that that interest is not sufficiently substantial nor direct to require them to have separate representation. We take the position that Commission Counsel has a role to play in representing their interest. If they have any concerns they can certainly make them known to Commission Counsel, and since this is really, sir, a question of degree and the exercise of your discretion, it is our submission that their interest would be adequately represented by Commission Counsel and they do not meet the test of substantial and direct interest.

Those, sir, are our submissions on standing.

THE COMMISSIONER: All right.

Mr. Percival?

MR. PERCIVAL: Mr. Commissioner, you have expressed certain concerns during the course of argument. We share those concerns. It is your decision: we leave it to you, sir.

THE COMMISSIONER: All right.

MR. YOUNG: If I plan to take any position at all it is the position on the various parties has been fairly put forward. I think I ought to say insofar as Mr. Ortved is concerned that his







J-4

1  
2 clients, the doctors, that he raised an issue during  
3 his cross-examination of Dr. Bunt which had to deal  
4 really with the responsibility for the deaths becoming  
5 known, on who lay the responsibility of bringing to  
6 light the circumstances that existed in the Hospital.  
7 That was raised by him during his cross-examination.

8 There will be Coroners testifying, and  
9 to put it bluntly, I think Mr. Ortved, the thrust  
10 of his cross-examination, was to shift the responsibility  
11 for the failure to identify a problem and to bring it  
12 to the attention of the appropriate police authorities  
13 from the doctors who were there on a day to day basis  
14 at the Hospital onto the Coroners, and that is a  
15 matter that I am sure will be pursued during the  
16 second Phase to the extent that Coroners or doctors  
17 are testifying, and insofar as it relates to the  
18 investigation that may be circumscribed to some  
19 extent.

20 So I say this at this point, that to  
21 the extent that issue may again arise in Phase II  
22 then he may well have an interest in cross-examining  
23 certain witnesses where that point will be addressed.  
24 To that extent I make known that situation now so there  
25 is no suggestion at a later point that he has been  
prejudiced in any way.





J-5

1  
2 Other than that I have no position  
3 with respect to any of the parties who request  
4 standing.

5 THE COMMISSIONER: Mr. Lamek?

6 MR. LAMEK: Mr. Commissioner, first  
7 with respect to something said by my friends, Mr.  
8 Shanahan and Mr. Tobias, I should like to be plain  
9 about this that although considerations of time and  
10 proceeding quickly to an end are properly important  
11 to you, it should be clear if there is any question  
12 at all that it is known to all of us that is a  
13 secondary consideration and very much so, and that  
14 paramount is a determination to have a full, fair,  
15 public hearing with complete rights of audience  
16 given to everyone who can establish a reasonable  
17 claim to participate.

18 The track record on Phase I I suggest  
19 can leave no doubt in anyone's mind: doubts as to  
20 standing, and even I may say as to funding were  
21 resolved in favour of the inclusion of the parties  
22 rather than of their exclusion.

23 I know that you, sir, will not base  
24 any decision on standing on considerations of time  
25 and expediency, and that should not be a matter of  
concern to anybody.





J-6

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With respect to Mr. Shanahan's suggestion that perhaps a further amendment to the Order in Council be sought to permit participation of parents, may I say respectfully I agree with my friend Mr. Brown that the real obstacle, if there be one to the participation of parents, lies not so much in the Order in Council as in the Public Inquiries Act under which this inquiry is proceeding, and the provision in Section 5(1) that in order to have the right to participate by the giving of evidence, calling and examining and cross-examining witnesses, someone must first satisfy the Commission that he has a substantial and direct interest, and it is on that question I think that the question of standing of the parents or anyone else falls to be determined.

May I respond only to applications for standing by four groups? First, the doctors and the 39 nurses represented respectively by my friend Mr. Ortved and my friend Miss Kitely. In my submission each of them has shown an arguable basis for standing. There has been some reference in the course of submissions to limited standing.

I don't read the Act as contemplating any such kind of standing at all. What the Act does contemplate and what in my submission it is essential







J-7

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to bear in mind is that there be a careful definition of the direct and substantial interest that standing is designed to protect, and a firm resolve on the part of the counsel for those groups, and on your part, sir, to restrict participation to that interest as defined.

I don't mean to be offensive, believe me, but I confess that I have wondered from time to time during Phase I whether Nurses Nelles and Trayner were represented at least in part by Miss Kitley and her partners. The course of her questions has led I think to the kind of questions you put to her this morning.

It is essential in my submission that it be clear from the outset of Phase II and that there be rigorous adherence throughout Phase II to the principle that a grant of standing to a particular interest is not a mandate for a roving Commission to explore any and every piece of evidence however remote that evidence may be from the particular interest for which the standing was granted.

Subject to that, sir, it is my submission that my friends Mr. Ortved and Miss Kitley have made a reasonable case for standing for the individual and doctors and nurses they respectively







represent.

With respect to the application for standing for the Registered Nurses Association of Ontario I confess that I, sir, do not see that the Association has a direct and substantial interest in the subject matter of Phase II.

My friend Miss. Kitley says that the nurses were involved in the investigation and therefore the collectivity of nurses should have some standing here. With great respect I cannot follow that.

If I as a lawyer were present in Court when my lawyer colleagues and opponents were unfortunate enough to be present when some unpleasant demonstration or violence broke out, I would be involved in that too, and I would be involved if I were present in a place where lawyers are present. I might be injured. I might be interviewed by investigators. I might be called as a witness in some prosecution or proceeding. I might be happy or unhappy with the treatment that I received in that process. I might be content or I might be resentful of that. I simply cannot see that it be a matter of professional interest for the Law Society.

In short, sir, I simply don't see that nursing issues which are of kind, as I





J-9

1  
2 understand it, of the Association, arise in Phase II.  
3 I was never sure that they properly arose in Phase I  
4 but I feel strongly that they do not in Phase II,  
5 and therefore in my submission no basis has been  
6 shown for the granting of standing for the Association  
7 in Phase II.

8 Finally, with respect to the parents,  
9 sir, it is a very difficult matter because we all  
10 must have -

11 THE COMMISSIONER: You said finally?  
12 I don't think you dealt with Mrs. Trayner.

13 MR. LAMEK: No, I don't propose to  
14 make any submission with respect to that, sir.

15 With respect to the parents it is  
16 a very difficult question because we all must have -  
17 indeed we all do have - the keenest sympathy with  
18 the position of the parents with relation to this  
19 whole process.

20 I confess to having very great difficulty  
21 with the proposition that the parents' interest in  
22 law enforcement and the administration of justice even  
23 in cases which affected their children or arose out of  
24 matters affecting their children is in any way  
25 different from that of the public at large.





J-10

1  
2 I concede that they are interested in  
3 what happened. I concede that they are intensely  
4 and keenly interested in what happened. In my  
5 submission to be interested in what happened is not  
6 what is contemplated by the Act which calls for an  
7 interest, substantial and direct, in the subject  
8 matter of the inquiry.

9 In Phase I I happen to believe that  
10 it was legitimately recognized that the parents of  
11 Baby X had an interest more acute and different from  
12 the interest of anyone else in the world in knowing  
13 what happened to Baby X; how and by what means that  
14 child came to its death. Whether the police did  
15 a proper adequate job of investigating the death,  
16 whether their search led them in the correct direction,  
17 whether the prosecution was properly conducted,  
18 whether it ever should have been conducted at all,  
19 are matters of great public concern. But I am  
20 obliged to say, sir, I don't see the special position  
21 of parents with respect to those matters and therefore  
22 in my submission the applications of Counsel on  
23 behalf of parents for standing in Phase II should be  
24 rejected.

25 THE COMMISSIONER: All right. Thank  
you.







J-11

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I will reserve the matter and I will make a ruling on it at least by early next week.

I want now to read a statement with regard to the application to hear argument in Phase I in camera.

As has been stated this matter has been released to counsel because it is important to counsel to know how they are to prepare their argument. I want to make clear the reasons for reaching the conclusion that I have reached and in this public inquiry to make those reasons public.

.....





K  
D/cr

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2 We are shortly to proceed to argument  
3 in Phase I. Mr. Hunt for the Attorney General asks  
4 that part of that argument be heard in camera. The  
5 circumstances are as follows:

6 Phase I is an investigation into  
7 "How and by what means" 36 children, who died in the  
8 Hospital for Sick Children, came to their deaths.  
9 The Court of Appeal has ruled that in my Report I  
10 may not, if I should find that the cause of death  
11 was an overdose of digoxin, identify the administrator.

12 The argument that Mr. Hunt seeks to  
13 have in camera is that which relates to the identity  
14 of the administrator.

15 Mr. Thomson, counsel for one nurse,  
16 supports him and goes further; he argues that no  
17 argument should be received at all which relates to  
18 identity. In this he is supported by Mr. Brown,  
19 counsel for another nurse, but if such evidence is  
20 to be received Mr. Brown asks that it be in public.

21 Counsel for the R.N.A.O. and many  
22 other nurses takes no position on either issue. All  
23 other counsel who participated in the argument oppose  
24 both proposals.

25 I can shortly dispose of Mr. Thomson's  
motion. As I have said, I am required to find out and





1  
2 report on how these children died and the evidence  
3 of identity has been received at least partly to that  
4 end.

5 It may help to characterize the deaths,  
6 i.e. whether they were the result of digoxin poisoning  
7 or not and if the former, may determine whether that  
8 poisoning was accidental or deliberate. I may not  
9 accept the argument, but it is at least arguable and  
must be received.

10 Mr. Hunt's motion stems from the concern  
11 felt by all of us - the desire to avoid in this very  
12 public Inquiry needless damage to individual  
reputations.

13 While some of the evidence may have  
14 already pointed in a certain direction, counsel may  
15 in argument focus that evidence more precisely upon  
16 one or more persons with a view to showing that the  
17 presence of that person or persons at the critical  
18 time of each death demonstrates a pattern from which  
19 an inference of digoxin poisoning can be drawn.

20 It is very tempting to accept the  
21 proposal. The media will understandably report every  
22 allegation made against every individual person and  
23 the public may treat those allegations as fact.  
24 Whether they do or not, the very real danger can be  
25





1  
2 avoided completely by in camera hearings.

3 Notwithstanding the great potential  
4 advantage, I have come after much reflection to the  
5 conclusion that I must reject the proposal.

6 First and foremost, this is a public  
7 inquiry. The Attorney General upon the introduction  
8 of the Order-in-Council establishing the Commission  
9 stated to the Legislature:

10 "...we are of the view that a full public  
11 inquiry is the only method available to  
12 ensure a full public airing of all the  
13 facts referred to in the Terms of  
14 Reference.

15 The deaths, the legal proceedings which  
16 follow the deaths and the subsequent  
17 enquiries and investigations, some of  
18 which have not been made public, have  
19 left unanswered questions of great  
20 public concern.

21 It is in the interests of the parents of  
22 the children, the dedicated personnel  
23 at the Hospital for Sick Children, and  
24 the administration of justice generally  
25 that the many issues raised, to the  
extent that it is humanly possible, be







"dealt with in a public forum."

The Public Inquiries Act provides as follows:

"All hearings on an inquiry are open to the public except where the Commission conducting the inquiry is of the opinion that,

(a) ...

(b) Intimate financial or personal matters or other matters may be disclosed at the hearing that are of such a nature, having regard to the circumstances, that the desirability of avoiding disclosure thereof in the interest of any person affected or in the public interest outweighs the desirability of adhering to the principle that hearings be open to the public, In which case the Commission may hold the hearing concerning any such matters in camera."

That appears to give me authority to hold in camera sessions, but clearly the onus is upon those who seek to have them, and I cannot find the onus satisfied in these circumstances.





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2 The Commission has not received any  
3 evidence in camera (although some argument as to the  
4 reception of evidence has so been conducted), and  
5 inevitably the public conception of the integrity of  
6 the Commission will be adversely affected if we now  
7 retreat behind closed doors to discuss the validity  
8 and importance of that evidence.

8 I may be restricted somewhat in what  
9 I can say in my Report, as to the manner in which I  
10 reached my conclusions, but if the argument leading  
11 up to the Report is not open to the public, their  
12 opportunity to judge the validity of those conclusions  
13 will be seriously hampered and many members of the  
14 public might for that reason reject those conclusions  
15 out of hand.

15 I read my instructions at the beginning  
16 as dictating that all proceedings of this Commission  
17 had to be public. There have been some unfortunate  
18 consequences of that decision and I regret them. I  
19 can only say that the consequences of the opposite  
20 decision would have been worse.

20 There is another reason, and not so  
21 important, for rejecting the motion and that is its  
22 impracticability. Each counsel would have to arrange  
23 his argument so that he could give part of it in public  
24  
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1  
2 and part of it in private. Some of it would be very  
3 difficult to classify in advance and there would  
4 necessarily be a long separation of the two parts unless  
5 we were prepared with each counsel to move in and out  
6 of camera, a most disruptive process. These problems  
7 have been overcome with great co-operation from all  
8 counsel which I am sure would have been forthcoming  
9 notwithstanding the opposition of the vast majority to  
10 the proposal.

11 Nevertheless, the argument would have  
12 become much more complicated and might have suffered  
13 in consequence.

14 While I reject the proposal, it does  
15 not of course mean that counsel are totally free to  
16 say anything relating to an alleged administrator  
17 of poison. Counsel will appreciate that every part  
18 of their argument must relate to something I can  
19 report upon and that generally is the cause of death.  
20 Counsel should bear that in mind in the course of  
21 preparation and delivery of argument. I shall try  
22 to be vigilant and I hope that counsel for the persons  
23 affected will take timely objection when there is  
24 a transgression.

25 Finally, I have a word of advice which  
I trust will not be misunderstood or resented. Counsel







1  
2 must, of course, act in the interests of their clients  
3 but there is never any merit - with me at least - in  
4 overstatement. Here, because of the very public  
5 nature of the case, extravagant language should be  
6 meticulously avoided. It will do no good for the cause  
7 of counsel's client; it may do great harm to the  
8 reputation of parties and indeed to the Commission  
9 itself.

10 We will rise until 2:15 and we will  
11 start the argument on Phase I.

12 ---Luncheon adjournment at 12:45 p.m.  
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--- Upon Resuming

THE COMMISSIONER: Yes,  
Mr. Lamek.

MR. LAMEK: Mr. Commissioner,  
before we finally get to argument on Phase I  
there are a couple of matters of evidence on  
Phase I, if I may.

Sometime ago, a couple of weeks  
ago, Mr. Tobias and I spoke to Dr. DeSa, who  
you will remember is the author of the death  
report which was part of the Atlanta Study on  
Pathology and sought clarification of one paragraph  
in his report. He gave us that clarification  
on the telephone and undertook to write,  
setting it out in a letter which he did. I have  
circulated that letter to all Counsel with a  
request that anyone let me know if they had  
any difficulty about the letter being filed  
as an Exhibit. I have heard from no one. I  
ask that I tender that, the letter of May 11th  
from Dr. DeSa to me as the next Exhibit.

THE COMMISSIONER: 421.

--- EXHIBIT NO. 421: Letter from Dr. DeSa.

MR. LAMEK: I give no undertaking  
that this next one will be the final Exhibit of





1  
2 Phase I. I suspect it may be. You some time  
3 ago, sir, asked that the Coroner's investigation  
4 statements, which had not previously been filed,  
5 be now filed, and again they have been  
6 accumulated into a bundle and copies have  
7 been distributed to all Counsel and I ask,  
8 please, that that bundle be marked as the next  
9 Exhibit.

10 THE COMMISSIONER: That will  
11 be 422.

12 --- EXHIBIT NO. 422: Coroner's investigation  
13 statements.

14 MR. LAMEK: I am told by  
15 Ms. Cronk that we are still missing some  
16 of these investigation statements. When they  
17 become available, again we will furnish them  
18 to Counsel and tender them.

19 THE COMMISSIONER: Thank you.  
20 What was the previous one? Do you remember  
21 the number?

22 MR. LAMEK: 150.

23 THE COMMISSIONER: There is  
24 a distinction. I can't remember it. We had  
25 an Exhibit 150. These were the ones in the  
ordinary course 150, and 422 will be the ones --





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MR. LAMEK: None of us can now remember, sir, why they came in two bundles in that way.

THE COMMISSIONER: I think it was because, and I could be wrong, but I think if you look at them you will find that Exhibit 150 were all ones which were reported to occur in the ordinary event.

MR. LAMEK: Yes.

THE COMMISSIONER: And the ones in 422 are ones that I think may have been either in the course of the preliminary enquiry or after it was over or something of that nature. Some day you can find that out for us, could you, Mr. Hunt?

MR. HUNT: Yes, I will.

THE COMMISSIONER: -- What the reason was. That I think will be the answer. 422 for the second bundle of Coroner's investigation statements.

ARGUMENT BY MR. LAMEK

MR. LAMEK: Mr. Commissioner, on June 21st, 1983, I made an opening statement in which I outlined the course that I proposed to follow in adducing evidence in Phase I of







1  
2 your enquiry. I tell you, sir, it was a  
3 salutary experience as these exercises often  
4 are and I recently went back to remind myself  
5 what I had then said. I would be grateful if  
6 you and if everyone else in this room refrain from doing  
7 that and if enthusiasm cannot be restrained  
8 then I would be grateful if people would  
9 refrain from reminding me of some of the  
10 things that I said.

11 Certainly the naivety of  
12 my optimism in predicting that the medical  
13 evidence might be completed by the end of  
14 July last year was very quickly exposed on  
15 Mr. Cimbura, the very first witness, who spent  
16 the first week in the witness box giving  
17 basic evidence about doing digoxin assay  
18 techniques. In my own defense I can only  
19 say that I had heard someone, who I will  
20 not name, express the view that the entire  
21 enquiry will be completed in six months, and  
22 guided by--

23 THE COMMISSIONER: The first  
24 time in my life that I agree with the Court  
25 of Appeal.

MR. LAMEK: --guided by my





1  
2 unfailing respect for the opinions of members  
3 of the Court of Appeal, I was proceeding  
4 on June 21st, 1983 on the assumption that  
5 that schedule was attainable and it was not  
6 to be the last time my faith in curial  
7 infallibility was shaken since that time.

8 In other respects though, sir,  
9 the observations that I made a year ago  
10 proved a little more accurate and I hope at  
11 least I lived up to some of them.

12 In the peroration of that  
13 opening statement I said this, and it is  
14 found at pages 41 and 42 of volume 1. I  
15 said:

16 " Mr. Commissioner, you are  
17 embarking upon an enquiry  
18 of enormous complexity. One  
19 cannot say where all this  
20 evidence may lead, and  
21 despite all the work that  
22 has been done today by others  
23 and despite all the publicity  
24 that's attended the events  
25 which are the subject matter  
of the Commission, one can





1  
2 have no preconceptions of  
3 where this trail of evidence  
4 will end.

5 From what I know of the evidence  
6 that we are likely to hear,  
7 I have to say that I approach  
8 these matters in an attitude  
9 of puzzlement. I can only  
10 say that I intend to bring  
11 before you, sir, all  
12 relevant and available  
13 evidence to assist you to  
14 determine and to assist the  
15 people of this Province to  
16 understand what happened at  
17 the Hospital for Sick Children  
18 and what happened in the  
19 investigation of those events  
20 and in the prosecution of  
21 Miss Nelles. "

22 I make no apology whatsoever for having described  
23 the Enquiry as one of enormous complexity.

24 Miss Cronk and I, with the  
25 unfailing support and assistance of commission  
staff have, indeed, attempted over the course of







1  
2 11 months, to place all available relevant  
3 evidence before you. Over the next couple  
4 of days Miss Cronk and I will deal with  
5 much of that evidence, but before I turn  
6 to any of it, sir, I hope I may be permitted  
7 to say a couple of things about the manner  
8 and the atmosphere in which this enquiry  
has been conducted.

9 We all recognized from the  
10 very beginning that the task that we were  
11 about was one in which there was the most  
12 intense public interest and was one which  
13 could profoundly affect the lives of people  
14 and of institutions. Perhaps uppermost in  
15 all of our minds was the anguish of the parents,  
16 whose children had died, and who wanted, indeed  
17 needed to know, how and by what means they  
18 had died. We were conscious too of the  
19 concerns at and about the Hospital for Sick  
20 Children, the concerns of the medical nursing  
21 and administrative staff of the Hospital, who  
22 had lived and worked with the question of what,  
23 indeed, had happened on the cardiology wards over  
24 the period from the summer of 1980 until March  
25 of 1981 and had done so in the unrelenting light





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of success of investigations and public

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questioning, and we were conscious too of

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the concerns of the public whose confidence

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and pride in a great hospital appeared to

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have been badly shaken.

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We were also at that time very aware that if the evidence should lead to the conclusion that some of the baby deaths were attributable to foul play, the consequences of anyone found to have been involved in such deaths were extremely grave. But in short, although we may have embarked on Phase I, sir, without any true appreciation of the magnitude of the task we were under no illusion about its importance or its sensitivity.

In the performance of the task choices had to be made from time to time between competing interests, and choices of that kind where the interest of one party was subordinated to another interest can never by their nature be acceptable to everyone. Those whose interests are subordinated feel aggrieved, and the public on the basis of more or less complete information forms a judgment commending or condemning the choice. I do hope though that to all who have been intimately involved in the proceedings of this Royal Commission, whether as parties or as counsel or as regular representatives of the news media, this much at least is clear, that at no time have the rights, the legitimate interests or the reasonable expectations of any person or group been treated lightly in a cavalier fashion or without respect for consideration.





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2 I say that, sir, not in any spirit of  
3 self congratulation or by way of defence or accolasia,  
4 but I know that you, sir, have never given anything  
5 but the most anxious consideration to the resolution  
6 of any conflict between clashing interests in these  
7 proceedings.

8 So far as concerns Miss Cronk and  
9 myself we have attempted openly to disclose in  
10 advance to each witness and to his or her counsel  
11 any information in our possession which might be  
12 damaging to or might call for an explanation from  
13 that witness.

14 I know that according to our likes  
15 we have struggled to be fair to everyone, and I  
16 suppose that knowledge should be enough and to be  
17 comfortable to say of the poet: "That one's strength  
18 is the strength of 10 because one's heart is pure".  
19 I am compelled to say that I have been from time to  
20 time stunned by accusations that we have been con-  
21 ducting a "witch hunt" in these proceedings. That is  
22 the word that has been used and it has a fine emotive  
23 ring of outrage to it. I reject it utterly and I  
24 reject this suggestion that these proceedings have  
25 been callously stage managed so as to direct attention  
unfairly to particular persons or groups. Miss Cronk







1  
2 and I have not created evidence, we have dug for it  
3 and we have adduced it openly exposing it to cross-  
4 examination by all in the hope that with whatever  
5 substance it may have when it emerges from that  
6 process it may prove of some assistance to you in  
7 your difficult task.

8 I regret profoundly what has gone on  
9 here should have been seen by some as unfair or un-  
10 feeling. If I have said or done anything to feed  
11 that perception I regret that even more. I can only  
12 say it had never been the intention of anyone concerned  
13 with this Commission to speak, to act unfairly or to  
14 create any impression of unfairness.

15 I referred a moment ago, sir, to the  
16 information which has been available to the public  
17 and that leads me to say something which I believe  
18 needs to be said about the way in which the news  
19 media have covered this very complex matter. Beyond  
20 question this has been the most complex matter.  
21 Beyond question this has been the most public public inquiry  
22 ever held in this country. Since the day we began  
23 over a year ago there have been virtually daily  
24 reports, in print, on radio and on television of our  
25 proceedings.

The presence of television cameras





1  
2 at our hearings has been regarded as a major departure  
3 in this jurisdiction, although it was not entirely  
4 novel as you, sir, know from Mississauga. It was  
5 nonetheless regarded as an experiment. It would not  
6 be appropriate for me to comment on the broadcast  
7 use that has been made of the video tapes made here,  
8 but I can I believe I should say that in my view the  
9 in-hearing room presence of cameras and audio tape  
10 recorders has not been a disruptive or destructive  
11 element here. There have been occasional complaints  
12 that one or another counsel has been playing to what  
13 Mr. Roland in a happy tone of phrase called the  
14 "Electronic jury", whether the complaints were  
15 justified is not for me to say but I am not persuaded  
16 that the propensity to play to the news media is  
17 either heightened or reduced by the particular news  
18 media audio or video which happens to be in attendance.

17 I hope that no witness has felt  
18 intimidated by the thought of being on camera. To give  
19 evidence at all must be an extremely stressful  
20 experience as perhaps we lawyers with our long  
21 familiarity with the process are too prone to forget.  
22 For some of the witnesses who appeared here the  
23 experience must have been extremely gruelling and I  
24 hope sincerely that the emotional wear and tear  
25





1  
2 on those witnesses was not aggravated by the presence  
3 of cameras.

4 So far as concern of the content of  
5 news reporting I say only this, sir, that although I  
6 have on two occasions voiced complaints about press  
7 comments which were based on blatantly wrong information.  
8 I believe that this Commission and the public have been  
9 generally well served by balanced responsible  
10 reporting particularly by those who have expended the  
11 resources, the time and the effort to follow closely  
12 a long and very complicated story.

13 Now, Mr. Commissioner, as you have  
14 observed in another context, the interests represented  
15 before you in these proceedings are many and varied.  
16 The potential for clash and conflict has been present  
17 throughout. Indeed whenever this number of lawyers  
18 is contained at close quarters for an extended period  
19 of time one must expect occasional irritability,  
20 heated exchanges and confrontation.

21 One of the truly remarkable and  
22 gratifying aspects of these proceedings has been the  
23 infrequency of such incidents. Counsel have not  
24 always agreed with you, or you with them, or they  
25 with each other, and that is as it must be in the  
system under which we operate, but the very high level







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of mutual respect which has prevailed is in my  
submission certainly worthy of note.

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It is not my purpose to embarrass  
or to flatter you, Mr. Commissioner, but even in a  
public inquiry counsel is permitted occasionally to  
say nice things about his client. I say that the  
almost total absence of acrimony from these pro-  
ceedings is in very large part a product and a  
reflection of the patient good humour with which you  
have conducted this Inquiry. It has been on your part  
a palpable desire of reason and fairness and it has  
influenced all of us.

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While I refer to counsel who have  
been involved here I want to take this opportunity  
please to record publicly my very sincere appreciation  
for the openness and co-operation of all counsel.

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Miss Cronk and I have never been  
refused any information that we requested. Every  
effort has been made to make clients and witnesses  
available to us for interview and preparation and  
our task in the whole of this long process has been  
made vastly easier by the helpfulness of counsel.

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The interests represented by counsel  
here are indeed disparate, and no less disparate are  
the personalities and the styles and the objectives





1  
2 of counsel. For all that I want to say, sir, because  
3 upon the completion of Phase I argument this entire group  
4 of counsel will never come together again. I want to  
5 say that I am indeed grateful to all counsel for  
6 their co-operation and to say that working with them  
has been a very pleasurable experience.

7 Over the course of Phase I hearings,  
8 sir, occupying some 147 days, we have heard from 51  
9 witnesses. Of those witnesses 18 were physicians who  
10 were at the Hospital for Sick Children during the  
11 epidemic period so-called, and of those 18 five were  
12 staff cardiologists, four were pathologists, two were  
13 clinical pharmacologists, others were residents and  
14 we heard also from Dr. Carver and Dr. Bain respectively,  
the current and the former Chief of Paediatrics.

15 We have also heard from five physicians  
16 not connected with the Hospital for Sick Children,  
17 Doctors Fay, Hastreiter, Kauffman, Mirkin and  
18 Seccombe; from two biochemists with the Hospital;  
19 from four epidemiologists and a statistician; from  
20 14 members of the Hospital nursing staff during the  
21 epidemic period; three parents and from Mr. Cimbura  
22 the Centre for Forensic Sciences; Dr. Bunt a coroner;  
23 Dr. Magee a nursing expert; and Dr. Gilmour-Bryson a  
medievalist, a computer user and compiler of statistics

24

25





1  
2 and a consultant to the Commission.

3 We have had crash courses, even in  
4 the case of Dr. Rowe's evidence an extended emersion  
5 course in a number of more or less archaeon disciplines,  
6 cardiology, biochemistry, toxicology  
7 and pharmacogenetics, resuscitation procedures,  
8 nursing practices and procedures and epidemiologic  
9 methods.

10 In each of these areas we have all  
11 reached the stage where we recognize most of the  
12 words and we can occasionally pronounce them  
13 correctly, and even though less frequently use them  
14 correctly.

15 For much of the time, and particularly  
16 in the early weeks of our hearings we were all toiling  
17 up a very steep learning curve and this has been one  
18 of those cases, sir, where the factual evidence as  
19 to who did what and when, and who saw what and when,  
20 can only make sense in the context of an acquired  
21 store of medical and scientific information. But  
22 all of that evidence is now before you and the time  
23 has come to attempt to sift the truly relevant from the  
24 less relevant or irrelevant, and to stitch the relevant  
25 evidence into a picture of what if anything occurred  
on the cardiology wards of this remarkable Hospital in







1 the nine month period which began June 30th, 1980.

2 In preparation for making submissions  
3 to you Miss Cronk and I have decided with, I hope your  
4 leave, to divide matters between us, and after I have  
5 made certain submissions of a general nature I shall  
6 ask you to hear Miss Cronk who will review and make  
7 submissions with respect to the evidence about  
8 digoxin. She will deal with among other things the  
9 biochemical evidence as to assay techniques, including  
10 the evidence about substance X; pharmacological  
11 evidence as to the action of the drug, its distribution  
12 within the body; the significance of particular levels  
13 of concentrations of the drug in serum and tissue;  
14 the problems of interpretation of serum in tissue  
15 concentrations; complications of ante or post mortem  
16 sampling, the post mortem multiplier effect in fresh  
17 and fixed and exhumed tissues. We will deal with the  
18 toxicological evidence and the evidence of the  
19 clinical pharmacologists as to dosage size and time  
20 and route of administration that are compatible with  
21 the concentrations recorded in certain of the children  
22 whose deaths are under review.

23 When Miss Cronk has dealt with that  
24 material I propose then to review the evidence, medical,  
25 pharmacological and circumstantial as to each of the







1  
2 36 children and to make submissions as to the  
3 conclusions that may be reached as to how and by what  
4 means each of those children died. I would hope, I  
5 hope I have learned to be a little more realistic in  
6 my estimates than I was a year ago. I would hope the  
7 submissions of Miss Cronk and myself should be  
8 completed on Wednesday or perhaps Thursday morning.

9 Now, Mr. Commissioner, in considering  
10 what might be helpful to you as you prepare to report  
11 on how and by what means the children came to their  
12 deaths on these wards in the nine month period under  
13 review, I concluded that the appropriate starting  
14 point was to construct and outline chronology with  
15 some comment as I went along. Chronology of course  
16 is frequently of assistance towards an understanding  
17 of a chain in events, but if it is to be helpful a  
18 chronology I suggest has to do more than list the  
19 sequence of events in the order in which they happened.  
20 The spacing of events is also very important. The  
21 period in which nothing occurred, and I say a very  
22 great deal about events which followed each other in  
23 rapid succession.

24 For example, one period of time in  
25 the epidemic period when very little happened and it  
was sort of a peaking period of time, one period of





1  
2 time when very little happened in the way of baby  
3 deaths was the daily recurring period between 8:00 a.m.  
4 and midnight. Now certainly some children died in  
5 that part of the day or evening, and I will refer to  
6 them later. In certain cases they were children whose  
7 sequence of terminal events had started prior to 8:00  
8 a.m. and in some few cases they were children who  
9 declined and died during the day and early evening,  
10 but deaths in the period from 8:00 a.m. until midnight  
11 were really very much the exception in the epidemic.  
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And it may be that to discern what was causing the deaths to occur in the night time hours, it is helpful to ask why more children did not die during the day time hours.

Similiarly it may be significant that deaths did not occur in a regularly spaced pattern over the epidemic period. I will get into this in more detail later, sir. You will recall I know that July and August saw a lot of deaths. The death rate declined very substantially during the fall and early winter, and then soared in December and dropped off again in January, built up a little in February and reached unprecedented heights in March.

It may be that if one can't find an explanation for the troughs in that sequence one might better understand why the peaks occurred.

The third example of what I mean, although this is more situational than chronilogical, is the observation of the 33 of the 36 deaths in the epidemic period one or more members of a single nursing team were on duty at the time of death or at the time of the onset of critical symptoms.

THE COMMISSIONER: I thought the figure was 35. I may be wrong.

MR. LAMEK: I believe there were three







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for which no member of the team was on duty and they were Floryn, Heyworth and Leith.

THE COMMISSIONER: I don't think that is correct. I may be wrong. I thought members of the team were present for all of them except Leith. In that I may be wrong.

Are you saying Heyworth and Floryn -  
MR. LAMEK: And Leith I believe were the three.

THE COMMISSIONER: Well at the onset of critical symptoms I understand that Susan Nelles and Sui Scott, Marianna Christie and Janet Brownless were all present. I am now looking at Laurette Heyworth. Who was the other one besides David Leith?

MR. LAMEK: Floryn.

THE COMMISSIONER: Well, I believe that Susan Nelles, Sui Scott and Marianna Christie were all present.

MR. LAMEK: Mr. Commissioner, I can check it. It is not vital for my present purpose but I will check it and get the information absolutely right for you.

THE COMMISSIONER: They weren't present at the time of death.

MR. LAMEK: At the time of death, yes.





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THE COMMISSIONER: Because Floryn, the last one - you may be right. At any rate that was the information that I had whether it is true or not. Anyway, you have an ally in Miss Cecchetto so perhaps you will prove me wrong.

MR. LAMEK: We will find the truth. Whether it be right or wrong.

THE COMMISSIONER: All right.

MR. LAMEK: The point I think was this, Mr. Commissioner: for over two years it has been observed that a strong association existed between so many of the deaths and one or more members of one nursing team. That has been known for a long time now. But in attempting to determine whether the deaths were natural or accidental again it may be instructive to ask why so very, very few deaths occurred in nine months in the presence of any other teams.

One would have thought if the deaths were entirely natural that there would have been a more random distribution among different nursing teams. It is not so much that one team was present for many deaths - that is important - it is deaths did not occur in the absence of that team which is perhaps of at least equal significance in attempting to decide whether deaths are natural or not natural.





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Mr. Percival has established in the course of his cross-examinations the exposure of patients to the one nursing team was 25 per cent. It was one of four teams. Indeed the exposure to the team at night was only 12½ per cent. It spent half of its time working the day shift. I will say more about this later, but I suggest, Mr. Commissioner, it is evidence that you can properly consider when weighing the likelihood that deaths occurred naturally or by accident.

Let me come then to an outline chronology and its reports to be no more than that, sir..

I take it as a starting point. January 1st, 1979, and in that regard I refer to Exhibit 34 which is one of the charts prepared by Dr. Gilmour-Bryson of on-ward deaths for each of five nine month periods.

You will see, sir, the first of those periods begins January 1st, 1979. Now that chart is in raw numbers of deaths. It is not expressed in terms of death rate per number of patients, patient days. Raw numbers to the extent of their value do show that for the four nine month periods recorded other than the epidemic period the number of deaths range between one and seven, and in the two nine month







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2 periods which preceded the epidemic period, deaths  
3 on ward were five and six respectively.

4 That I suggest is corroborative of  
5 Dr. Rowe's evidence which is found in Volume 10,  
6 page 1727, beginning at line 20. I don't ask you to  
7 turn to it, sir. I think I can reasonably summarize  
8 it. Corroborative of Dr. Rowe's evidence that  
9 relatively few patients died on the cardiology ward  
itself.

10 Cardiology patients tend to die in  
11 the operating room or in the I.C.U., either being in  
12 the I.C.U. after surgery or sent to the I.C.U. because  
13 their condition on the ward has deteriorated, but  
14 only comparatively rarely did a patient die on the  
15 ward was Dr. Rowe's evidence. And the numbers  
16 disclosed that Dr. Gilmour-Bryson's chart is indicative  
17 of that for those earlier periods: five and six  
deaths in two nine month periods.

18 • When the raw numbers are translated  
19 into mortality rates as they were by the authors of the  
20 Atlanta Report (that, of course, sir, is Exhibit 324,  
21 and in particular I am looking at page 50; take figure 3)  
22 there the authors of the report in order to provide a  
23 true comparison, three month period to three month  
24 period, expressed the deaths in terms of mortality  
25







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2 rates, and the rate as stated at the left hand side of  
3 the chart, deaths per 10,000 patient days, and they  
4 with the three month period starting in 1976, were  
5 recording mortality rates over three month periods  
6 ranging from one to four right up until the epidemic  
7 period.

8 Indeed it is interesting to note both from  
9 table 3 to the Atlanta Report and from the text itself,  
10 page 6 that the mortality rate did not change materially  
11 in the three months immediately following the move  
12 from Ward 5A to Wards 4AB. There was not an immediate  
13 effect on mortality rates when the service moved to  
14 its new quarters on the fourth floor with the larger  
15 number of overall beds and the larger number of  
16 patients.

17 Although expressed in different units  
18 the information produced by Atlanta, page 50 and figure 3  
19 is clearly consistent with that produced by Dr.  
20 Gilmour-Bryson; again corroborative of Dr. Rowe's  
21 observation as to the relative infrequency of deaths  
22 on the cardiology ward. In my submission those  
23 statistics provide a base line or bench mark against  
24 which the events of the epidemic period may properly  
25 be measured.

On April 1st, 1980, the cardiology





CC-7

1  
2 service was removed to new quarters on the fourth floor.

3 The aggregate number of beds was increased from 38  
4 to 42, and in particular the number of infant beds was  
5 increased to 18. New nursing teams were formed;  
6 new team leaders were appointed, but as the Atlanta  
7 authors point out and their statistics demonstrate,  
8 none of that had any apparent immediate effect on the  
9 mortality rate on Wards 4AB.

10 At 6:00 o'clock in the morning on  
11 June 30th, 1980, Laura Woodcock died. She was a  
12 patient on Ward 4B and she began symptoms - she didn't  
13 die at 6:00 o'clock - she began to exhibit cardiac  
14 irregularities and a drop in blood pressure, and that  
15 marks the beginning of a decline in the course of which  
16 at 7:30 in the morning complete AV block was recorded,  
17 and subsequently in the early part of the long day  
18 shift of June 30th, Baby Woodcock suffered a cardiac  
19 arrest from which she could not be revived and she  
20 died as I recall at 9:30 in the morning.

21 It appears from the chart as do the  
22 matters that I have just summarized, and in particular  
23 page 51 of the chart, at the time of her death there  
24 was no ready explanation seen for her sudden decline  
25 and arrest. The Coroner was notified. After autopsy  
the physicians felt more comfortable with the death,





CC-8

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and I will have more to say about that in detail when we come to discuss the cause of death of Laura Woodcock later, and in the result the death appears to have been accepted as not too surprising.

Then during July five more deaths occur. On the afternoon of July 8th, Baby Alan Perreault died on Ward 4A. Nobody was surprised. Indeed Dr. Rowe's evidence was that the surprise of Baby Perreault was that he lived as long as he did. He was irreversibly sick. A do not resuscitate order was in place. In short the occurrence of Baby Perreault's death a little more than a week after that of Baby Woodcock did not and understandably in the circumstances did not give rise to any questions of concern on anybody's part.

But in the last ten days of July, four more deaths occurred: Baby Taylor died on Ward 4B on July 27th, and Babies Bilodeau, Dawson and Hoos died on 4A on July 22, 28 and 31 respectively.

Now, Mr. Commissioner, I believe it fair to say that the staff cardiologists although naturally upset by the deaths did not see any cause for concern or for an unusual investigation. I want to say more about that in a few moments but I want to make it clear right now that in making that







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observation which I believe to reflect the evidence I intend no criticism of the physicians or of the Hospital Administration. But equally, however, it does appear that the nurses on the floor were looking for answers by the end of July, and that I suggest is entirely understandable.

They were the people who had watched the decline and death of six patients in the period from June 30th to July 31st. Four of those deaths occurred in the middle of the night, a time when in the normal course nurses do not have the comfort of having experienced staff cardiologists available on the floor to deal with crises and to calm their own concerns.

A ward meeting was held on July 31st, and the note which is found in Exhibit 300, which is the communications book, under the tab 4A Communications on page 5. Reference to this note had been made over and over again so I won't take the time to read it.

July 31st was the day that Lillian Hoos had died. She had died earlier that morning. Later in the day there was a discussion of, among other things, recent deaths. It is clear from the note of the meeting that the preliminary results of





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autopsy on Lillian Hoos were already available. The  
note on Lillian Hoos at that meeting of July 31st,  
reads:

"The Waterston Shunt was widely  
patent, p.m. showed chylothorax,  
questioned cause of death - it has not  
been settled yet".

Clearly the autopsy had been conducted  
by the time of this meeting and the preliminary  
results reported back, and it was equally clear that  
no explanation had yet been found for the death of  
Lillian Hoos, and no cause of death had been isolated  
and none had yet been determined on Amber Dawson for  
whom reference was also made at that meeting.

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It appears also from the same page of the 4A Communication Book against the date 5/8 that sometime on or prior to the 5th of August, Dr. Rowe commented that our recent deaths were all because of anatomy that could not be fixed.

Dr. Rowe, it appears, had indeed to the knowledge of the nurses, expressed his view that the deaths were attributable to the irreparable anatomical conditions of the patients.

I pause to say, sir, parenthetically, that the applicability of that observation attributed to Dr. Rowe, the applicability of that observation to the case of Amber Dawson is not immediately apparent but, of course, Amber Dawson's anatomy had been fixed. I will return to that point later when I deal with that death in greater detail.

By the time Dr. Rowe's comments was recorded in the Communications Book there had been a further death, of course, that of Baby Turner in the wee hours of August 1st. There is no doubt in my submission, sir, on the evidence you have heard, no doubt but that





DD-2

1  
2 first Dr. Rowe sincerely held the belief that  
3 he has recorded as having expressed  
4 and second, that the nursing staff derived  
5 very considerable comfort from Dr. Rowe's  
6 stated view, which relieved their natural  
7 concern of which you have heard that perhaps  
8 some failure of observation or reaction on  
9 their part may have contributed to the deaths.

10 On August 8th, page 6 of the  
11 Communications Book, sir, there was further  
12 news from the autopsy on Amber Dawson, a  
13 finding of an abcess on the diaphragm. It  
14 may be difficult with the benefit of  
15 detachment and hindsight to understand why  
16 disclosure of that finding served to relieve  
17 the continuing question, as to the cause of  
18 Baby Dawson's death, but it appears to have  
19 done so. In my submission there is no reason  
20 to doubt the truth of the nurses' evidence  
21 in that regard or to be critical of what  
22 may now seem to have been a too ready acceptance  
23 of such an explanation.

24 Between August 9 and August 24  
25 four more babies died on the wards, Baby Shrum  
on August 9, Baby Monteith on August 19th, Paul







DD-3

1  
2 Murphy on August 23rd and Velasquez on  
3 August 24th, all on Ward 4A. Baby Shrum and  
4 Murphy died in the evening, Babies Monteith  
5 and Velasquez died in the middle of the night.  
6 Again, one of these deaths, and I refer you  
7 to the death of Paul Murphy, was not in  
8 any way surprising. He was almost 17 years  
9 old, but he was sadly, clearly not going to  
10 survive. A DNR Order, 'Do Not Resuscitate Order'  
11 had been written on that child -- a young man.  
12 Varying degrees of surprise were caused by  
13 the other deaths. Velasquez's death in particular,  
14 caused great concern. He was recovering  
15 from surgery. He was soon going to be sent  
16 home to St. Lucia. Notwithstanding the comfort  
17 that they had derived from Dr. Rowe's assurance  
18 early in August that the July deaths had  
19 been attributable to the hopeless cardiac  
20 conditions of those babies, the nurses again,  
21 understandably, continued to be concerned about  
22 the number of on-ward deaths. On June 30th  
23 to August 24th, eleven children had died  
24 in the cardiology wards.

25  
Dr. Rowe, the Head of the  
Cardiology Division, was apprised of those concerns





DD-4

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2 and was responsible for the convening of two  
3 morbidity and mortality conferences held in  
4 September, but at each of those meetings  
5 there was discussion of babies who had died.  
6 I think it is fair to say that the overall  
7 thrust from Dr. Rowe and his colleagues at  
8 those meetings, was that the children, who  
9 had died and whose deaths were discussed, were  
10 extremely sick and that the nurses had done  
11 everything possible for them. There was  
12 also discussion at those meetings of the  
13 desirability of an ICU-like facility on  
14 Ward 4AB to provide closer monitoring and  
15 presumably, possibly a faster response to  
16 early signs of problems.

17 In the context of the  
18 mortality and morbidity conferences, or is  
19 the other way around, the one held on  
20 September 5th, in particular, I suggest it  
21 is important to say this: looking back again  
22 at all the clarity of hindsight, at the  
23 discussion at that meeting, as it is recorded  
24 in Nurse Radojewski's notes in the Communications  
25 Book, one cannot help but be struck by the  
references of to what we recognize as symptoms





DD-5

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2 of digoxin intoxication in the case of  
3 David Taylor. In page 11 of the Communications  
4 Book, in Nurse Radojewski's note of the  
5 meeting, David Taylor, Sunday evening, two-thirds  
6 of the way down the page, is recorded as  
7 having exhibited irregular heart rate, ST  
8 depression on an ECG, vomiting, AV block,  
9 ventricular fibrillation and, indeed, the  
question was expressly noted dig.toxic.

10 In the notes of the second  
11 mortality and morbidity conference -- these  
12 are found at pages 16 to 19 -- the written 16,  
13 not the printed. It has got a printed 15 at  
14 the top righthand corner.

15 The notes on Dion Shrum, which  
16 are found on page 18, handwritten, 17 printed,  
17 refer to symptoms which again we would now  
18 recognize as being perhaps suggestive of  
19 digoxin intoxication, irregular pulse, complete  
20 heart block, seizure and arrest. It may seem  
21 to us, looking back at those notes, that the  
22 signs were there to put physicians and nurses,  
23 particularly physicians on notice, on enquiry,  
24 as to the possibility of digoxin involvement  
25 in the deaths. The evidence has been, of course,







DD-6

1  
2 that nobody made any such connection or had  
3 any thought that these deaths were anything  
4 other than the result of the diseased conditions  
5 of the babies in question. Yes, a question  
6 was raised about digoxin toxicity with respect  
7 to the child at the first meeting, but the  
8 death was not considered to have been  
9 digoxin-related.

10 It was clearly recognized  
11 that an unusual number, an unusually high  
12 number of deaths had occurred over the  
13 summer, but according to Dr. Rowe, and there  
14 is no reason in my submission to doubt for  
15 a moment his account, according to Dr. Rowe,  
16 the staff cardiologist, found explanations  
17 for that phenomenon in the observations that  
18 deaths often come in clusters and the impression  
19 that the cardiology wards were populated by  
20 younger, sicker patients and in the impression  
21 that the wards were understaffed at night.  
22 As for that last impression, there has been  
23 no evidence of understaffing at night and  
24 certainly none to indicate that understaffing  
25 may have contributed to the incidents of  
death. One would have thought that the nurses,





DD-7

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2 themselves, who were clearly concerned to  
3 understand why they were losing patients  
4 in unprecedented numbers, and who worried  
5 that any action or omission by them was  
6 contributing to the high death numbers, one  
7 would have thought that the nurses would have  
8 been complaining of being understaffed if  
9 they felt that that was the case. I have  
10 no knowledge or recollection of any such  
11 complaint in the evidence.

12 As for the physicians'  
13 impression, they were dealing with a younger,  
14 sicker ward population and that therein lay  
15 the explanation for the deaths, the great  
16 irony of this whole situation is that according  
17 to the Atlanta Report their impression was  
18 accurate. The ward population, which is found  
19 at page 10 of the Atlanta Report, sir, the  
20 ward population in the epidemic period was  
21 indeed on the advice of Atlanta's consultants,  
22 younger and more seriously sick than in other  
23 periods, but again, according to the Atlanta  
24 Report, page 16, table 7 at page 39, the patients  
25 who died in the epidemic period were generally  
less seriously ill than those who died in the





DD-8

1  
2 other periods.

3 In other words, the Atlanta  
4 perception to be correct, the physicians'  
5 impression as to the characteristics of the  
6 ward population was absolutely right, but  
7 it did not, in fact, provide an explanation  
8 for the deaths.

9 In my submission, one should  
10 not be critical of the hospital or of the  
11 physicians on that score. It is easy to say  
12 that more searching questions should have been  
13 asked or that people should have been more  
14 alert to pick up clues and patterns. In  
15 hindsight explanations, such as clustering,  
16 bad luck, coincidence, may be thought to  
17 have been too readily acceptable. Because  
18 clustering, after all, although it may be  
19 a recognized phenomenon, doesn't really  
20 satisfactorily explain all of these deaths  
21 when one could look back over the whole  
22 situation. Not only were the deaths apparently  
23 appearing in clusters, there was a time clustering,  
24 as to the small number of hours of the 24 and  
25 a personnel related clustering, the presence  
of the same nursing team. Had those features







1  
2 been seen there might have been a less ready  
3 acceptance of clustering as an explanation.

4 We know from the evidence,  
5 I think, particularly the evidence of Miss  
6 Coulson and of Mrs. Johnstone, the latter being  
7 found in volume 108, pages 4471, 4478, 4481, 4482,  
8 we know that some nurses were aware of those  
9 common features, deaths at night, presence  
10 of the same team, as early as the first week  
11 in August of 1980. When Mrs. Johnstone got  
12 back from vacation, she talked to Miss Coulson  
13 about it. Miss Coulson made those observations  
14 to her at that time. Those observations do  
15 not appear to have been passed on or become  
16 plain to the physicians until a month later.

17 My submission, though, is this,  
18 Mr. Commissioner: criticism of the hospital or  
19 of the physicians or of the nurses for not  
20 having recognized the possibility that something  
21 may have been seriously amiss on the cardiology  
22 ward is harsh and at bottom, as I say,  
23 respectfully, is not particularly relevant to  
24 the question upon which you have to report,  
25 how and by what means the children died.

It is in my submission, doing







DD-10

1  
2 the best I can to put myself in the context  
3 in which they were then looking at these  
4 deaths in the fall of 1980, is entirely  
5 understandable that the medical and nursing  
6 staffs of a hospital would ascribe innocent  
7 explanations to the multiple deaths which  
8 occurred. The idea that something other than  
9 innocent events might be occurring would simply  
10 not occur to them.

11 We heard this from concerned  
12 members of the hospital staff, even at late  
13 stages of the epidemic period. Miss Coulson  
14 even in December and January, when she could  
15 no longer accept that bad luck and coincidence  
16 were explanations for the deaths, even when she  
17 felt in her words that "something was going on",  
18 she couldn't conceive or perhaps bring herself  
19 even to contemplate, the possibility that  
20 somebody might be harming patients. She racked  
21 her brain and speculated about problems of  
22 IV solutions. She thought of any crazy thing  
23 rather than grapple with the other possibility.  
24 It was not one that came to her mind or she  
25 did not allow to come to her mind. Her evidence  
is found in volume 106, pages 4029 to 30.





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Mr. Commissioner, I am  
about to return to the chronology in the fall  
of 1980. Is this a good time?

THE COMMISSIONER: We will  
take 20 minutes.

--- Short Recess





EE-1

DM/hr

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--- Upon resuming

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THE COMMISSIONER: Yes, Mr. Lamek.

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MR. LAMEK: Thank you, sir. I was

about to return to the chronology following the references to the mortality and morbidity conferences in September. In the fall of 1980 the mortality rate clearly dropped from the level that it had reached in July and August; two children died in September, three in October, one in November, and after the mortality rates of the summer months those three months no doubt seemed to be a return to relative normality. Dr. Rowe was away in the Fall. When he left he expected further mortality and morbidity conferences to be held, they were not. He returned earlier in December and found there had been no more conferences. He expressed himself gently here, I suspect he expressed himself rather less gently in the Hospital at the time.

In December the number of deaths returned to the same high level that had been experienced in July and August, five children died in the Wards in December; Onofre on December the 9th on Ward 4B; MacDonald, December 13th, Gosselin, December the 18th, Lombardo, December the 23rd, all on 4A, and Belanger on December the 28th, normally on Ward 4B at the time







E-2

1  
2 of the wards combination, and the concerns about the  
3 number of deaths were understandably revived. As I  
4 have said it was about this time that Miss Coulson  
5 on her evidence, she was one of the night nursing  
6 supervisors you will remember, she said she had to  
7 face up to the fact that she could no longer accept  
8 coincidence as an explanation for so many deaths in  
9 the presence of the same nursing team.

10 It was in December that Dr. George  
11 Trusler the cardiovascular surgeon spoke to Dr. Rowe  
12 and then wrote to him Exhibit 64, the letter of  
13 December the 15th, 1980. Now Dr. Trusler's concern  
14 was that he and his surgeon colleague, Dr. Williams  
15 were getting patients through surgery, through the  
16 I.C.U. back to the ward only to have them die on the  
17 ward at the time when he, Trusler, regarded them as  
18 being out of danger. He listed seven patients who  
19 died in such circumstances and plainly he was concerned  
20 to find an explanation. Now when Dr. Trusler wrote  
21 that letter of December 15th, there had been two  
22 ward deaths in December, we had Onofre and we had  
23 MacDonald. By the time Dr. Rowe replied on December  
24 the 29th and his reply is part of Exhibit 64, by  
25 December the 29th there had been three more ward  
deaths, two of them were Babies Lombardo and Belanger





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1  
2 who died six and five days respectively after surgery.  
3 Dr. Rowe when he responded to Dr. Trusler's letter  
4 was forthright enough to say that Dr. Trusler's  
5 list of seven patients could be amplified without  
6 much trouble. He raised questions in his letter  
7 about the need for facilities for closer monitoring  
8 of babies that who were at risk, and about the need  
9 for surgical reintervention in certain cases. In  
10 the result a meeting was convened on January the 11th,  
11 1981, to review the deaths that had occurred since  
12 the previous summer, and the minutes of that meeting  
13 are Exhibit 65, sir.

14 At the meeting 20 deaths were reviewed,  
15 and I put the word reviewed in oral quotation marks.  
16 Fifteen of the deaths were described as unexpected;  
17 although you may recall Dr. Rowe's evidence as found  
18 in Volume 12 on page 2054 that by the term "unexpected"  
19 he meant only that a death was not an inevitable one  
20 and that some intervention might have been possible  
21 to prevent it.

22 Now, I said I put the word reviewed in oral  
23 quotation marks I mean that the 20 deaths were not  
24 individually discussed at that meeting. There was  
25 no review of particular charts or particular patients  
at the meeting, and there was no discussion of the





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cause of each death. In my submission it is not unfair to say that the meeting of January 11th, 1981 was held on the basis of certain assumptions which were not questioned or challenged or changed at the meeting. The first was that each and every one of the 20 deaths had been a natural death, and certainly there is no indication either in the minutes or in Dr. Rowe's evidence to suggest that that assumption was challenged. Second, the assumption, the conclusion indeed that ~~perhaps~~ in certain cases more prompt re-operation might have saved the patient and in other cases more intensive monitoring facilities might have saved the patient. In my respectful submission the major object of that meeting was to gather support for the creation of an intermediate I.C.U.

I put that light on the meeting because that in my submission serves to explain, or make more comprehensible, the events that occurred a few days later. On the early morning of the day that the meeting was held Janice Estrella died. Her death was reported in the early hours of the morning by telephone to Dr. Freedom, who ordered that a blood sample be drawn an autopsy for digoxin assay. That is the evidence of Dr. Taylor the pathology resident who did the Estrella autopsy and it is found







E-5

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in Volume 43, pages 8610 to 8611 and 8614. When Dr. Freedom gave evidence here he said he had no recollection of having received a call or having given such an order. In my submission the evidence of Dr. Taylor on the point should be accepted for these reasons.

In the first place Dr. Taylor's evidence makes sense. He said that Freedom told him in giving the order that Estrella had had high digoxin levels during her life, as indeed she had, and he wanted to know the post mortem concentrations. Second, on other occasions, Dr. Freedom had spoken to others of having received a call from Taylor and that he asked Taylor to obtain a post mortem blood sample for digoxin assay. He apparently said that to Mr. McGee, the Crown Attorney, and that is found in Volume 30, pages 548-549.

THE COMMISSIONER: If I could just look at that.

MR. LAMEK: It was put to him by Mr. Percival I believe, or perhaps Mr. Hunt, I am not sure, 548-549, I clearly have the page wrong, I clearly have the page wrong, it can't be 548-549 I will find it for you, sir.

THE COMMISSIONER: We have 29.







EE-6

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MR. LAMEK: The reason I hesitated in reading it, my note is a little unclear and I obviously have it wrong and I will provide you with that one, sir.

You will also recall that Dr. Freedom in interview, the tape of which was played here, had told a CBC radio reporter that he was awakened by a call from Taylor and in a half awake state ordered the digoxin level in the belief that Estrella was still alive. He put it to us, or gave it to us that that had been a reconstruction of a possibility that he had given to the CBC reporter, and I think fairly the transcript of the interview, or the tape of the interview did not bear out that it was given as a hypothetical possibility but more as a matter of recollection. For those various reason what he said to Mr. McGee at an earlier stage, he apparently said to the CBC, and the fact that Taylor's evidence has a ring of plausibility about it, Freedom made his request for the reason that Taylor says he gave, lead in my conclusion to the probability that Taylor's evidence is the correct evidence and that Dr. Freedom's inability to recall doesn't really deny the fact that matters happened as Dr. Taylor said they did. It may not matter hugely, but I am obliged to say that





EE-7

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it is odd that Dr. Freedom's memory should apparently be so variable on the event.

In any event blood was drawn as we know, not at but after autopsy, from the pelvic cavity, so called gutter blood and was milked from a leg vein. Some days later according to Dr. Taylor it was within a week, that I believe is found at Volume 43, page 8660, according to Dr. Freedom some two to three weeks, and that is in Volume 29 at 5442, some time after the events the result was received by Taylor from the lab and the results were greater than 4.7 and 72 nanograms per millilitre respectively. Now curiously Dr. Taylor did not go rushing off in search of Freedom with that rather startling news. His own evidence found in Volume 43 at 8660 to 8661 is that he bumped into Freedom in the Hospital cafeteria and discussed the results with him there. He did not mention the level of 4.7. He told him only about the 72 nanogram level and he says that he told Dr. Freedom that he, that is Taylor, thought it was a crazy number and he said the specimen had been obtained in such a way as it was likely to have been contaminated. Again, according to Dr. Taylor's evidence, Dr. Freedom's response was that the 72 level was likely an error or an artifact





EE-8

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2 and he said that Taylor should check it out, that is  
3 also found in Volume 43 at pages 8663-8665; Taylor  
4 did not check it out.

5 Now Dr. Freedom in his version of the  
6 conversation didn't say that Taylor had raised the  
7 possibility of contamination but he does say that he  
8 had a very casual conversation with Taylor about the  
9 matter. In Volume 29 at 5543 and following he says,  
10 and the words are interesting:

11 "He asked me in sort of a casual fashion  
12 what do I think of the level of 72 in  
13 Janice Estrella. My recollection of  
14 the conversation was 'Jesus that value  
15 is so out of hand it is either a  
16 calculation error, a decimal error,  
17 a problem with the biochemistry or  
18 perhaps the sample had been drawn from  
19 a contaminated source.'"

20 He says he told Taylor that Taylor should check back  
21 with biochemistry and get back to him. Dr. Freedom,  
22 on his evidence did not make any inquiries about the  
23 reading; Taylor didn't make any inquiries and he  
24 didn't get back to Freedom and Freedom didn't follow  
25 up. The end result the recorded level on Janice  
Estrella disappeared into limbo never to reappear until







E-9

1  
2 March when the Pacsai level threw the Hospital into  
3 a turmoil, it just was dropped.

4 Now, on the face of it, Mr. Commissioner,  
5 the evidence as to the way in which the sample came  
6 to be drawn from Baby Estrella, and as to the apparently  
7 extraordinary response to the level reported by the  
8 lab, on the face of it that is startling evidence.  
9 One might well suggest that the whole episode  
10 manifested a rather cavalier attitude to the  
11 circumstances surrounding the death of that child.  
12 I suggest again that it is difficult to be too  
13 critical because further inquiry would no doubt have  
14 revealed the suspect source of the sample in which  
15 that 72 level was recorded, and that having been  
16 discovered I suggested that it is probable that the  
17 level would not have raised a general hue and cry,  
18 or clicked on any lights to reveal other possible  
19 explanations for the spate of ward deaths that  
20 had occurred.

21 I come back to the meeting of January  
22 the 11th and suggest that by the time of that meeting  
23 the physicians and surgeons, by the time they left  
24 that meeting, had really reached a consensus, a  
25 conclusion, as to why so many children had died.  
Without attempting to justify or condemn the events





EE-10

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following the death of Baby Estrella, I suggest one  
could reasonably infer that the attention of the  
medical men had become so focused on the cause of  
and solution to the problem as they had defined it,  
that attention was not likely to be diverted by anything  
short of the clearest and most compelling evidence  
pointing in another direction.

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The implications of Janice Estrella's 72 nanogram level if that level were accurate were obviously too horrendous to contemplate. The reported level had to be wrong. She had not been on the drug for four days, and it was assumed to be wrong without any further enquiry.

Perceptions would not change until Dr. Costigan took the Pacsai levels to Dr. Carver on March the 18th, two months later.

THE COMMISSIONER: To a certain extent this has been dealt with already, and I am referring to the Dubin Report at page 158. I don't know whether you are saying more than is said here:

"However, the result of the digoxin level test was received at the very time that studies were underway relating to the increased number of deaths on the cardiac ward. Under those circumstances caution at least should have dictated further enquiry. There is some suggestion that a further test was directed. No such test was made and there appears to have been no follow-up. We think that something further should have been done before





1  
2 "the result of that test was rejected  
3 out of hand. In future we think  
4 further enquiries should be made of  
5 laboratory results which indicate  
6 something out of the ordinary even  
7 under circumstances which would render  
8 the original results questionable."

9 And do you go any farther than that?

10 MR. LAMEK: I don't think I go any  
11 farther than that at all, sir, no. Indeed the only  
12 thing I may have added to that, added by way of a  
13 gloss upon it, is the suggestion that as a result of  
14 the January 11 meeting the prior deaths were no  
15 longer a matter of question for the doctor. Perhaps  
16 they should have been. They weren't. They decided  
17 what the problem had been and they decided what they  
18 thought the solution was and they were setting about  
19 working on the solution, the intermediate ICU.

20 There was after January 11 perhaps  
21 less of a propensity to show concern for the prior  
22 deaths than there may have been before that meeting.  
23 I don't attempt to justify that, but I don't particularly  
24 condemn it either. I merely try to regard it as a  
25 fact put in the chronological sequence of events, and  
the number was a gross number. No one had ever seen







1  
2 a number like 72. The sadness is that on the one  
3 hand I suppose nobody followed it up, although  
4 instructions were given by Freedom that it be followed  
5 up. Taylor didn't do it. Freedom didn't do it.

6 THE COMMISSIONER: What was Taylor to  
7 follow up?

8 MR. LAMEK: Well, one of the  
9 possibilities that Freedom had raised was a possibility  
10 of a decimal error: Had they expressed the answer  
11 wrong? He could at least have found that out. That  
12 he could have done. Taylor said he had raised the  
13 possibility of contamination. Whether some explanation  
14 was made of that or could have been made of that I  
15 do not know.

16 Dr. Freedom was not particularly precise  
17 about what he had in mind by "check it out", but  
18 "check it out" seems to refer to the kind of mathematical  
19 calculation placement of a decimal point that he had  
20 listed as one of the possible explanations for that  
21 very high number. It is perfectly clear, however,  
22 that whatever he had in mind nothing was done.

23 Now on the other hand I say had  
24 something been done and had there been some explanation  
25 of the way in which the sample was drawn then what  
Taylor said he told Freedom at the time, that the





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1  
2 method of taking the sample just may well have  
3 produced a contaminated sample, would have led them  
4 in any event to disregard the result. After all the  
5 other result of which Freedom was unaware at that  
6 time, the greater than 4.7 was in a sense not  
7 inconsistent with the earlier levels in Estrella.  
8 It was higher than the last recorded ante mortem  
9 level in her which was 4.7 on the nose, but on the  
other hand a post mortem sample --

10 THE COMMISSIONER: I don't think at  
11 that time they knew the difference between a post  
12 mortem and ante mortem sample. I don't think  
anyone --

13 MR. LAMEK: They may not have.

14 THE COMMISSIONER: - possibly the  
15 pharmacologist may, but certainly the cardiologists  
16 did not.

17 MR. LAMEK: The pharmacologists may  
18 well have said to them at that stage, okay, but 4.7  
19 and greater than 4.7 doesn't mean anything; levels  
rise after death.

20 It may have been that even had  
21 enquiries been made a blank would have been drawn  
22 and a conclusion would have been reached in any event  
23 that a 72 level could have been disregarded. The  
24  
25





1  
2 sadness is that no enquiry was made.

3 But Estrella's was the only death in  
4 January. In February three children died in the first  
5 half of the month. Fazio, February 4, Floryn,  
6 February 7, Thomas, February 12. Floryn died on 4B;  
7 the others on 4A, and they died at 4:45, 6:20 and 3:38  
8 respectively in the morning.

9 Now no resuscitation was attempted of  
10 Bruce Floryn. He was a very sick child and not  
11 expected to survive. Codes were called on the other  
12 two. They could not be resuscitated.

13 But nothing that had occurred before,  
14 certainly not the experience of January and February,  
15 1981, prepared the staff of the ward or the  
16 cardiology division for what occurred in March. On  
17 the morning of March 6th at about 5:00 a.m. David  
18 Leith began to deteriorate. David Leith was another  
19 child for whom there was a do not resuscitate order.  
20 He died at 10:30 that morning.

21 From March 7th until March 22nd nine  
22 children died on the cardiology wards. All in the  
23 small hours of the morning except for Pacsai who got  
24 into trouble then and died some hours later in the  
25 ICU. All in the presence of one or more members of the  
same nursing team.







1  
2 Just for the sake of recollection  
3 those children were: March 7th, Warner, 3:45 in the  
4 morning. March 8th, Hines, 6:00 o'clock in the morning.  
5 March 9th, Gionas, 1:45 in the morning. March 12th,  
6 Manojlovich, 3:35 in the morning. Same night Pacsai  
7 10:10 in the morning. The next night, March 13th,  
8 Inwood, 3:00 o'clock in the morning. March 18th,  
9 Gardner, 4:25 in the morning. March 21st, Miller,  
10 3:27 in the morning and March 22nd, Cook, 4:56 in the  
11 morning. And by mid March similarities between these  
12 deaths, common thread patterns were becoming clear  
13 to everybody.

13 The night time deaths in a narrow  
14 time band had by now been so clearly seen that there  
15 was talk of the witching hour. If a night reached  
16 four or five o'clock without incident the staff breathed  
17 a sigh of relief. Coming to work on the long night  
18 shift was an unattractive thing. But it wasn't until  
19 March 18th that someone thought there might be some-  
20 thing terribly wrong on 4A/B.

20 That was the day that Dr. Costigan,  
21 Chief Resident, went directly to the Chief of Paediatrics,  
22 Dr. Carver, to tell him the terribly disturbing news  
23 about Kevin Pacsai's digoxin level. You will recall  
24 I know, sir, the circumstances in which Dr. Costigan  
25





1  
2 had ordered digoxin assays to be done on Pacsai.  
3 He was puzzled by Pacsai's elevated serum potassium  
4 in the hours prior to the baby's death, he was  
5 concerned by cardiac symptoms that were suggestive  
6 of digoxin intoxication, and about the possibility  
7 that steps that he had taken to lower the potassium  
8 level might have aggravated the effects of the digoxin.

9 Costigan ordered a digoxin level to  
10 be measured. He went in search of the remnants of  
11 a blood sample that had been drawn ante mortem for  
12 a complete blood count, and he furnished that to the  
13 biochemistry department for digoxin assay. That  
evidence is found in Volume 45, page 45 and following.

14 Interestingly, entirely independently  
15 of Dr. Costigan's effort, Dr. Cutz the pathologist  
16 having seen two references in the chart to possible  
17 digoxin toxicity, and those are the references of  
18 Dr. Costigan himself on the night the child died,  
19 decided at autopsy to take the unprecedented step on  
20 his own motion of drawing blood for post mortem  
21 digoxin assay. That evidence is found in Volume 42  
22 at pages 8538 to 9. Those results became available  
23 and Dr. Costigan took them to Dr. Carver on the  
24 morning, Wednesday, March 18th.

25 Dr. Carver's response was in my





1  
2 submission all that one could ask for. He immediately  
3 ordered an investigation into the digoxin on the ward,  
4 to check if it was indeed the correct strength  
5 preparation, and an investigation into the possibility  
6 of a drug error having produced the recorded levels  
7 in Pacsai, and he told Dr. Fowler to advise the coroner  
8 of this development.

9 As he told us in Volume 35, page 8607  
10 he did not at that time think that deliberate overdose  
11 might have produced the levels. Clearly there was  
12 something to be investigated. His mind turned  
13 initially to innocent explanations.

14 But from that point events began  
15 to move very fast indeed. Dr. Mancer the pathologist  
16 who had been in charge of the Estrella autopsy learned  
17 from Dr. Cutz of the Pacsai digoxin levels, and on  
18 March 20th took it upon himself to report the Estrella  
19 information to the coroner. That reference is Volume  
20 40 in Dr. Mancer's evidence, pages 8083 to 8085. In  
21 the result a meeting was called for the afternoon of  
22 Saturday March 21 between Dr. Carver, senior cardiologist  
23 in the Hospital, other Hospital staff, coroner and  
24 police, to discuss the Estrella and Pacsai cases.

25 Dr. Carver believes that it was on  
Saturday that he received an oral report from Dr.







1  
2 Fowler on the negative results of his investigation  
3 into the possible innocent causes of the Pacsai levels,  
4 and it was then for the first time that the possibility  
5 of foul play occurred to him.

6 Although Dr. Carver did not know it  
7 until after he returned to the Hospital on Saturday  
8 afternoon following a meeting with the coroners,  
9 Allana Miller had died in the early hours of that very  
10 day, and Dr. Costigan learning of the death when he  
11 came into the Hospital early that day had ordered  
12 blood drawn at autopsy for digoxin assay.

13 He so told Dr. Carver late in the  
14 afternoon of Saturday March 21st, and he told him  
15 because it was a weekend that the assay wouldn't be  
16 done until Monday. Apparently Dr. Costigan as Chief  
17 Resident did not have the clout to get the process  
18 going that evening. Dr. Carver as Chief of Paediatrics  
19 did.

20 A biochemist was brought in, did the  
21 assay that evening, and a level of 72 nanograms was  
22 reported at about 8:00 p.m.

23 Dr. Carver instructed Dr. Fowler to  
24 report the matter to the coroner, and he immediately  
25 convened a meeting at which Drs. Fowler, Costigan  
and Mounstephen were present, a plan of action was







1  
2 formulated and immediately implemented to protect  
3 patients by inventorying and securing all digoxin  
4 preparations on the wards.

5 Later Dr. Carver and Dr. Fowler met  
6 with Dr. Tepperman the coroner who arrived about 11:00  
7 o'clock. They told him of the steps that had been  
8 taken about locking up digoxin. There was a discussion  
9 as to whether the nursing team which had been on duty  
10 for each of the three deaths in issue (that is Estrella,  
11 Pacsai and Miller) should be relieved of their duty.  
12 It was decided that night that they should not.

13 Dr. Carver left the Hospital some time  
14 after midnight and he went home. The anguish of the  
15 night was not over for him yet. Five o'clock on the  
16 morning of Sunday, March 22nd, he received a call from  
17 Dr. Fowler reporting the death of Justin Cook, and it  
18 was decided in the course of that telephone conversation  
19 that blood should be drawn for digoxin assay and for  
20 a drug screen.

21 Dr. Jedeikin was instructed by Dr.  
22 Carver to take samples of the contents of the IV bag  
23 for digoxin assay, and Dr. Fowler was instructed to  
24 report the Cook death to the coroner. Biochemistry  
25 work on the Cook samples was done on an urgent top  
priority basis and Cook's digoxin levels were known





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later in the morning, and on Sunday the police were  
in the Hospital beginning their investigation.

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GG.1.1

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We know that further measures were taken to protect the patients. The Trayner team was told not to come into work that night. Supervisors were on the ward floor carrying the keys to the narcotics cupboard where the digoxin was now kept, supervising all medication and administrations. Digoxin levels were done on all patients on the cardiology wards. Steps were also taken then or shortly afterwards to move patients off the wards where feasible and to cancel elective admissions. In short, once the possibly ugly features of the situation were last recognized the hospital, under the leadership of Dr. Carver, responded vigorously and fully to the situation.

Mr. Commissioner, you have heard evidence of discussions and meetings in the week of Monday, March 23rd, which, in large measure, more closely concern Phase II than they do in Phase I. I don't propose to take the time here to refer to those matters.

One very important observation should be made, however, relating to the period from and after March 22nd, 1981, the mortality rate immediately reverted to its pre-summer 1980 historic level. There was not to be another







GG.1.2.

1  
2 death giving rise to similar concerns until  
3 that of Gary Murphy in April of 1983, about  
4 which I shall say some more later.

5 On the information that has  
6 been available to us here, sir, such deaths,  
7 as occurred on Wards 4A and 4B from and after  
8 March 22nd, 1981, have not been clustered in  
9 the middle of the night. There is every  
10 indication whatever had been happening on  
11 those wards from the summer of 1980, until  
12 March 22nd, 1981, came to an abrupt end following  
the death of Justin Cook.

13 And that, sir, is in very  
14 broad outline only a chronology of the events  
15 with which we have been concerned. I referred  
16 earlier to the spaces between events and the  
17 timing of events. There are, as you know, several  
18 patterns in the events which we are considering.  
19 One pattern, though, is apparently lacking, the  
20 spacing of deaths week in and week out, month  
21 in, month out, and on the face of it discloses  
22 no particular rhythm or pattern. June 30 to  
23 July 31, six deaths; the month of August, five  
24 deaths; the month of September, two; October, three;  
25 November, 1; December, 5; January, 1; February, 3;





GG.1.3

1  
2 March until March 22, 10. Now, if all of those  
3 deaths were natural deaths, resulting from  
4 the diseased states of the children, one would  
5 not be too surprised to see a random  
6 distribution, an uneven distribution of deaths  
7 from month to month, and taken in isolation,  
8 the month to month distribution that I have  
9 just recited does appear to be random, and on  
10 the face of it, therefore, taken in isolation,  
11 might arguably support a natural death theory.

12                   There are matters in my  
13 submission that give one pause in accepting any  
14 such argument, even leaving aside the findings  
15 of very high digoxin levels in some children.  
16 If by purely natural events the month to month  
17 incidents of death appears to be random and  
18 unstructured, one asks, why does not one find  
19 a comparable randomness of distribution of  
20 death during all hours of the day or all hours  
21 of the night and between all nursing teams  
22 working on the wards? The very fact that the  
23 hour of day distribution and the personnel  
24 distribution do not appear to be random, makes  
25 one at least enquire, I suggest, whether the  
randomness of the month to month distribution is





GG.1.4

1  
2 more apparent than real. On the other hand,  
3 if a conscious mind and will were at work  
4 to produce these baby deaths perhaps there is,  
5 indeed, a pattern to be discerned, even in  
6 the month to month incidents of deaths.

7 I make this submission, sir.  
8 It is rather a no-lose argument that I am  
9 making. Even if one cannot discern a pattern  
10 in that month to month incident, that does  
11 not necessarily negate the premise that a  
12 conscious mind and will were at work. If one  
13 postulates a baby killer, one has to acknowledge  
14 that the thought processes of such a person  
15 might not be what most of us call rational.  
16 It may be too great an assumption to think  
17 that any rational mind would act according  
18 to a pattern that more rational minds can discern,  
19 but operating for the sake of analysis on the  
20 premise of a deliberate killer, there are, in  
21 my submission, notable gaps or lulls in the  
22 deaths to be considered. The first one I am  
23 afraid I can cast no light upon and that is  
24 the period prior to June 30th, 1980. Why did  
25 our assumed killer, making that assumption for  
the sake of this analogy, why did that person







1.1.5

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2 only begin his or her activities then? Why  
3 not before?

4 I know from the evidence of  
5 no one, who had known continuing opportunity  
6 and access to these babies who first came to  
7 the wards of the hospital May/June of 1980.  
8 I do not know and certainly I have no speculation  
9 that I wish to offer, as to what it was that  
10 triggered the assumed killer into action.  
11 So that period of inactivity is, for all that  
12 I know, utterly unexplained.

13 Two: the lull from August 24th,  
14 until the end of November. It has been pointed  
15 out in the course of the evidence that Mrs.  
16 Trayner was away from August 24th until September  
17 24th. What of the ensuing two months? It may  
18 be important to bear in mind that the summer  
19 deaths had raised sufficient concern and  
20 questions in the minds of, especially nurses, that  
21 mortality and morbidity conferences were arranged.  
22 We know that two such conferences were held in  
23 September. One may infer perhaps that while those  
24 conferences were going on, while deaths were  
25 being scrutinized and discussed, the person  
responsible for the deaths might have thought







G.1.6

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it prudent to lie low, but even if that

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be so, what about October and November when

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no M & M conferences were held?

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GG.2.1

RD/ac

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2 The conferences were not held but you will  
3 recall Dr. Rowe's evidence that he intended  
4 and expected that they would be. He was away  
5 much of the fall, from October 15th until  
6 December 7th, and he was distressed upon his  
7 return to learn that no further conferences  
8 had been held.

9 Now, unless our assumed killer  
10 was the person responsible for arranging the  
11 M & M conferences, and that is a double speculation  
12 without a shred of foundation, the fact that  
13 there would be no further conferences in the  
14 fall of 1980 was not known to anyone. It was  
15 expected that the conferences would continue,  
16 that the scrutiny of deaths would continue,  
17 that the discussion of deaths would continue, and  
18 until it became clear that the fuss and discussion  
19 and scrutiny process was over and the heat was  
20 off perhaps our assumed killer would continue  
21 to lie low and that may be the explanation for  
22 the relative inactivity in the fall until  
23 December of 1980.

24 Dr. Rowe came back in early  
25 December. There was clearly no announcement  
that the M & M conferences would resume and the





GG.2.2

1  
2 deaths resumed December the 9th and five  
3 occurred during December and, therefore, the  
4 gap or lull in the fall may thus be understandable.

5 After the spate of deaths in  
6 December there was again a lull in January with  
7 one death in February with three before the  
8 explosion in March. Is there any explanation  
9 for that lull? There may indeed be one..

10 Although the M & M conferences  
11 did not resume in the form in which they had  
12 been held in September there was a large conference  
13 held on January 11th where 20 deaths were to  
14 be discussed. Now, that that meeting was going  
15 to be held was not even known to the convenor  
16 of the meeting, Dr. Rowe, until apparently  
17 December the 29th when he wrote his letter to  
18 Dr. Trusler. It is not even clear from the  
19 evidence that we have heard that the rank  
20 and file staff of the hospital employees, and  
21 I mean no disrespect, and I include people  
22 working on the front line, nurses on the floor  
23 and so on, no indication they even knew the  
24 meeting was to be held. It does seem that it soon  
25 became known that the meeting had been  
held, because there was discussion of this







G.2.3

1  
2 proposal of intermediate ICU.

3 It may not be mere coincidence  
4 that Janice Estrella died on January 11th,  
5 the very day of the meeting and there wasn't  
6 another death that month. It may be entirely  
7 possible again that that was because the heat  
8 was seen to be back on and deaths were once  
9 again under scrutiny.

10 It is difficult to find any  
11 explanation for the huge number of deaths in  
12 March 1981. One might think that seven weeks  
13 or so having passed from the January 11th meeting,  
14 perhaps a discussion of what had gone on there  
15 had now died down, someone may have been  
16 interested in re-activating these deaths, why  
17 to the extent they occurred in March is something  
18 there can be no informed speculation about.

19 But there were no deaths after  
20 the arrests of Susan Nelles and no deaths after  
21 that of Cook and certainly not after the arrest  
22 of Miss Nelles. There may be at least four  
23 more or less rational explanations for that,  
24 but let me stress there is absolutely no  
25 evidence for any of the first three of these.

The first possible explanation





GG.2.4.

1  
2 when one is considering the rational possibilities,  
3 is that the arrest of Miss Nelles removed the  
4 culprit. That would be one possibility. The  
5 second would be that someone other than Miss  
6 Nelles was the culprit, but found the situation  
7 was now so hot and dangerous and the risk of  
8 discovery so high that the deaths now had to  
9 stop. The third would be that someone other  
10 than Miss Nelles was the culprit, but with the  
11 arrest of Miss Nelles had achieved his or her  
12 objective of implicating Miss Nelles. There  
13 was no need to continue the deaths.

14 Fourth, perhaps most likely,  
15 changed conditions on the ward: secured digoxin,  
16 double signing, supervisors, dig. levels becoming  
17 routine made it impossible to continue without  
18 inviting almost certain detection.

19 In short, Mr. Commissioner, with  
20 respect to the gaps or lulls in the deaths  
21 and the apparent lack of any pattern, rhyme  
22 or reason and the timing of deaths from month  
23 to month, my submission is there may well be  
24 not a pattern, but a reason for the uneven  
25 sequence of deaths.

That brings me, sir, to general





GG.2.5.

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review of certain theories that have been

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advanced from time to time and attempts to

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explain what happened. It may be that rather

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than beginning at 25 past 4 I could do it at

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10 o'clock in the morning?

7

THE COMMISSIONER: Yes.

8

MR. LAMEK: Thank you, sir.

9

THE COMMISSIONER: We will

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rise until 10 o'clock tomorrow.

11

---Whereupon the Hearing adjourned at 4:25 p.m.  
until 10:00 a.m., Tuesday June 5th, 1984.

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